Dr. Christiana Marron, PLLC Patient Registration

Name: _____ Date: _____

Address:

_____

City: _____ State: _____ Zip: _____

DOB: _____ Phone Number: _____

Email Address: _____

Emergency Contact: _____ Contact #: _____

Whom May we thank for this Referral? _____

Patient's Signature: _____Date: _____

Dr. Christiana Marron, PLLC Patient Agreement and Consent

Consent to Treatment: I hereby authorize Dr. Christiana Marron, PLLC to examine and receive outpatient rehabilitation therapy services and any ancillary services that are deemed medically necessary or appropriate by my physical therapist and/or treating physician.

Release of Information: I hereby authorize the release of my health information, including reports of diagnoses, treatments, prognoses, recommendations, benefits payable, and any other information pertinent to my treatment by Dr. Christiana Marron, PLLC to my physician(s) and any other health care providers for medical purposes. I also consent to the release of this information for Dr. Christiana Marron's, PLLC day-to-day operations. I understand that my health information may include information relating to my health condition, care or payment for my care, including telephone numbers and other demographic information.

Assignment and Instruction for Direct Payment to Health Provider:

I further understand that Dr. Christiana Marron, PLLC is a fee for service Physical Therapy private practice and I am responsible for the cost of each session at the end of the visit.

Patient Signature: _____ Date: _____

Dr. Christiana Marron, PLLC Patient Notification Policy

Name: _____Date: _____

In compliance with the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule and our Notice of Privacy Practices, Dr. Christiana Marron, PLLC will not disclose your protected health information ("PHI") without your explicit authorization, except as permitted by law for the purposes of payment, treatment and health care operations.

Furthermore, Dr. Christiana Marron, PLLC will limit the use, disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. Therefore, Dr. Christiana Marron, PLLC will only disclose your appointment information, such as reminders or cancellations, on an answering machine, voice mail, text message or e-mail, unless you inform us otherwise.

This notice refers to Dr. Christiana Marron, PLLC as "us" and "our," and to the patient/guardian as "I," "my," "you," "your," and "yourself."

I, the undersigned, hereby authorize Dr. Christiana Marron, PLLC to disclose my appointment information by the following methods of communication and I assume all responsibility for ensuring that the methods of communication that I indicated below are secure, with password protection used where applicable:

Patient/Guardian Signature: _____Date: _ _____

If under the age of 18, parent/guardian over the age of 18 will be responsible for the patient and the patient's consent to treatment.

Parent/Guardian Name: _____ Relationship:_____

Phone # in Case of Emergency _____ _____

Patient/Guardian Signature: _____ Date: _ _____