



bio-mechanics OF LAS VEGAS

"Results Driven Health Care"

**Assignment Of Benefits / Consent To Treat
Release Of Information / Notice Of Privacy Practices**

I, _____, authorize Bio-Mechanics of Las Vegas to treat me. I authorize my insurance company to pay Bio-Mechanics of Las Vegas all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges whether or not paid by insurance. I consent to Bio-Mechanics of Las Vegas ("the Provider") use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for the purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes. I understand that the Providers' diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For the purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Provider, that relates to my past, present, or future physical or mental health condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me. I further authorize Bio-Mechanics of Las Vegas to release information regarding my care at this facility to the primary care provider I designate in my patient file.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Provider, but the Provider is not required to agree to these restrictions. However, if the Provider agrees to a restriction that I request, the restriction is binding on the provider.

I understand I have a right to review the Providers' Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Providers' duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time, except to the extent that the Provider' has acted in reliance on this consent.

Signature of Patient or Authorized Representative

Date

Name of Patient or Authorized Representative

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