Name: _____ Date of Birth: _____ Gender: F M

Address: _____ Social Security Number: _____

City: _____ State: _____ Zip: _____ Phone: _____

Emergency Contact: _____ Phone: _____

NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt By signing this form, you acknowledge that you have been offered a copy for review of Link Physical Therapy's ("LinkPT"). Notice of Privacy Practices which is prominently displayed in the clinic and available on our website. This Notice of Privacy Practices provides information about how we may use and disclose your protected health information. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice and if you have any questions about our Notice of Privacy Practices, please contact the clinic at 651-313-5859.

X X

Patient/Guardian Signature Date

Relationship to Patient

GENERAL CONSENTS AND ACKNOWLEDGEMENTS

1. I consent to and hereby authorize LinkPT, through its appropriate personnel, agents and affiliates to perform the evaluation, care and treatment procedures that are deemed necessary by my physician(s) and other healthcare providers (collectively my "Care"). I understand that no warranties or guarantees have been made to me about the outcome of my Care.

2. I understand that LinkPT works with accredited academic institutions, through clinical affiliations, to provide healthcare professionals in training with hands-on patient care experiences and opportunities to apply learned skills to actual patient care. I further understand that such healthcare professionals in training may be involved in my Care.

3. I understand that LinkPT will not be responsible for the loss, destruction or theft of any of my personal property. I take full responsibility for, and release LinkPT from any and all responsibility and/or liability for the loss, destruction or theft of my personal property at, or in the vicinity of, any LinkPT location or clinic.

4. I understand that I am not permitted to take pictures or make video or audio recordings at any LinkPT location or clinic or of my care, other patients or LinkPT personnel.

5. I understand that to ensure that patient inquiries are handled promptly, courteously, and accurately, some of the phone calls between LinkPT (or any of its affiliates, agents, assigns and service providers) and me (or anyone I have authorized to speak with LinkPT) may be monitored and/or recorded.

6. I understand and consent that LinkPT may from time to time make calls and/or send text messages to any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me and/or the account holder. I understand and consent that the way these calls or text messages are made may include, but is not limited to, the use of prerecorded/artificial voice messages and/or automatic telephone dialing systems. I understand that I am not required to agree to this provision as a condition of receiving services and that my consent may be revoked at any time.

7. I understand and consent that LinkPT may use and share my health information to bill and get payment from health plans or other entities. I permit a copy of this authorization to be used in place of the original.

8. I understand and acknowledge that my appointment times are scheduled in accordance with availability of professional staff. I understand that my appointment may be rescheduled by LinkPT if I arrive more than 15 minutes late.

X X

Patient/Guardian Signature Date