



## Client Consent Form

I give Advanced Orthopaedic Physical Therapy my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from my insurance companies, and for health care operations like quality reviews.

I acknowledge that I have been given a copy of Advanced Orthopaedic Physical Therapy's Privacy Practices.

I understand that Advanced Orthopaedic Physical Therapy has a right to change their privacy practices and that I may obtain any revised notices at Advanced Orthopaedic Physical Therapy's office.

I understand that I have the right to request a copy of my health disclosure report at any time. I also agree that I have the right to request a restriction of how my protected health information is used.

I understand that I may revoke this consent at any time, by making a request in writing.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
*(Patient, parent, or legal guardian)*

If signed by a patient representative, state relationship \_\_\_\_\_

**Advanced Orthopaedic Physical Therapy, PSC**  
9400 Williamsburg Plaza  
Suite 100  
Louisville, KY. 40222

Phone: (502) 412-4486  
Fax: (502) 412-4490  
Email: [Info@MyAOPT.com](mailto:Info@MyAOPT.com)