FED-HURT

You're In The Solution Now!

Patient Information

Patients Name: _____ Today's Date: _____

Date of Birth (Month/Date/Year) _____ Sex: M/F _____

Cell Phone Number: (_____) _____ - _____ Email Address: _____@_____

Mailing Address:

_____

Street City State Zip Code

General Information

DATE OF INJURY	Employer:	Job Title:
_____/_____/_____	Duties:	

Did you notify employer of your injury? Yes No Are you currently working? Yes No

If no, when was the last day you worked? _____

How were you injured? (mark one)

Overexertion: This includes injuries related to pulling, lifting, pushing, holding, carrying & throwing activities at work	**Struck Against and Object**: This happens when a person accidentally runs into immovable objects such as walls, doors, cabinets, windows, or furniture
Fall on Same Level Surfaces: This pertains to falls on work site and office floors	**Driving Incident**: An injury that occurs while driving for work
Fall to Lower Level: This type of fall happens from an elevated area such as a roof, ladder, or stairway	**Caught In/ Compressed By**: This type of injury usually occurs when large moving machinery catches a limb or clothing and pulls you in.
Bodily Reaction: These injuries caused by slipping or tripping without falling	**Repetitive Motion**: Repetitive motions such as typing or using the computer can strain muscles or tendons, causing pain
Struck by an object: Objects that fall from shelves or are dropped by another person	**Assaults and Violently Acts**: Attacks by co-workers or others

After Accident Information:

Did you fill out an accident report? Yes No *If yes, please provide us with copy.* Have you hired and attorney? Yes No

Immediately after accident, how did you feel? Dizzy/ Dazed Upset Weak Nervous Headache Disoriented

Unconscious Other: _____

Medical Care After Injury:

Admitted to Hospital?	Yes	No	Which Hospital?	Ph:
Did you see a doctor?	Yes	No	Dr. Name:	Ph:
Physical Therapy?	Yes	No	Name:	Ph:

Chiropractor?	Yes	No	Dr. Name:	Ph:
X-Rays Taken?	Yes	No	Location:	Ph:
Did you get an MRI?	Yes	No	Location:	Ph:
Other Medical Care?	Yes	No	Describe:	

Health History:

Pregnant? Yes No Weeks: _____ Nursing? Yes No

Medications: _____

Allergies to Medications? Yes No If yes, please list the medications: _____

Previous Injuries:

Have you suffered previous accidents or injuries? Yes No

If yes, please specify: _____

Do you have residual pain from previous accidents or injuries? Yes No

If yes, please specify: _____

Later Symptoms: (Please note any symptoms that started AFTER the injury occurred)

HEAD

Headache	Memory Loss	Light-headedness	Bump, Bruise, Laceration
Fainting	Blurred Vision	Double Vision	Other:_____
Dizziness	Ear Pain	Loss of Vision	

NECK

Radiating Pain in Shoulders or Arms	Popping in Neck	
Neck Pain	Muscle Spasms	Other: _____

SHOULDERS

Shoulder Joint Pain	Muscle Spasms in shoulder	Other:_____
Pain Across Shoulder	Can't raise arms above shoulder level	_____
Tension in shoulders	Cant raise arms over head	_____

ARMS AND HANDS

Pain in arms	Loss of grip strength	Swollen joints in fingers	
Pain in fingers	Pins & needles in hands	Numbness in left arm	
Cold hands	Pins & needles in fingers	Numbness in right arm	Other:_____

CHEST

Chest pain	Pain around ribs	Other: _____
Breast pain	Shortness of breath	

ABDOMEN

Nervous Stomach	Diarrhea	Abdominal pain	Other _____
Nausea	Constipation		

MID BACK

Sharp Stabbing	Muscle spasms	Pain between shoulders	Other: _____
Pain	Pain from front to back		

LOWER BACK

Sharp Stabbing	*Low back pain is worse when:*				Other:_____
Pain		Working	Sitting	Lifting	Bending
Muscle Spasms	Stooping	Coughing		Standing	Lying Down

HIPS, LEGS AND FEET

Pain in buttocks	Legs cramps	Numbness in leg	Other: _____
Pain in hip joint	Pins & needles in legs	Pain down leg	
Numbness in toes	Feet feel cold	Knee pain	

GENERAL

Nervousness	Depression	Sleep loss: _____hours per night
Irritability	Cramping	
Fatigue	Generally feeling run down	Other:_____

INFORMED CONSENT TO MEDICAL TREATMENT

I hereby consent to and authorize medical care and treatment as my physician, assistants or designeesmay deem

necessary or advisable. This care may include, but is not limited to, medical evaluations/examinations, physical therapy evaluations/examinations, physical therapy treatment/modalities, chiropractic care and/or administration of injectable medications (for pain relief) of my condition(s) by licensed medical doctors, physical therapists and chiropractors at Florida Spine & Sport DBA D. O. L. Injury Centers/ DBA 4FED-HURT also known as medical providers. I understand that my care is directed by my physician and that other personnel may render care and services to me according to my physician's instructions.

Cooperation with Appointments: I must come to scheduled appointments unless there are unusual circumstances. I understand and agree to cooperate with my physician and perform the physical therapy treatment/exercises and/or chiropractic adjustments intended for me as prescribed by my physician. If I have trouble with any part of my treatment program, I will discuss it with my therapist or physician.

No guarantee: I understand that there are no guarantees regarding a cure for or improvement in my condition. I understand that my medical providers will outline and discuss goals of physical therapy treatment for my condition and will discuss treatment options, including chiropractic adjustments, medications and/or injections with me before I consent to treatment.

Informed consent for treatment: The term "informed consent" means that the potential risks, benefits and alternatives of physical therapy treatment, chiropractic adjustments, medications and injections have been explained to me. The medical providers offer a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition.

Potential risks: I may experience an increase in my current level of pain or discomfort or an aggravation of my existing injury or condition(s). This discomfort is usually temporary; if it does not subside in a reasonable time period, I agree to contact my physical therapist or physician.

Potential benefits: I may experience an improvement in my symptoms and an increase in my ability to perform my work duties and daily activities. I may experience increase strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

Alternatives: If I do not wish to participate in the treatment plan and/or physical therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physical therapist, as well as my physician.

I have been given on opportunity to ask questions and all my questions have been answered to my satisfaction. I confirm that I have read and fully understand this consent form. In the event of a change in medical status, I understand that my treatment may be modified, stopped or referred out to the proper practitioner. I reserve the right to withdraw at any time.

Patient's Name:_____ Signature: Date: _____

MEDICAL RECORDS AUTHORIZATION FORM

Patient Information (Please Print)

_____

Patient Name **Last** **First** **Middle**

_____

Date of Birth (MM/DD/YYYY) **Treatment Dates (MM/YYYY-MM/YYYY)**

FOR HOSPITAL/URGENT CARE

I hereby authorize DOL INJURY CENTERS and its duly authorized agents and employees to □ RELEASE or □ OBTAIN the protected health information

indicated below to/from:

Name:_____ **Phone Number:**_____

Address:_____

Street **City** **State** **Zip Code**

Requested Information:

I authorize the disclosure of the following types of records created from _____ to _____

- Patient History
- Information created or received from other providers
  - Specify_____
- Hospital and Consulting Physician Summaries
- Pathology Reports
- Shot Records ONLY
- Lab Reports
- X-Rays
- Radiology Reports
- Entire Designated Record Set

Please send requested information to : 4fedhurt911@gmail.com

Your Rights: You may refuse to sign this authorization. Your refusal will not affect your ability to obtain treatment or payment.

1. If the persons or entities authorized to receive this information are not health care providers or health plans covered by federal health privacy laws, they may re- disclose the information and those laws would no longer protect the disclosed health information.
2. Once you sign this authorization, we can rely on it until you revoke it or, if you have not revoked it, until it expires. You can revoke this authorization by mailing a signed and dated letter to

Florida Spine and Sport Inc./dba
DOL Injury Centers/dba 4Fed-
Hurt
Privacy Officer
2240 SW 70th Ave. Suite DDavie, FL
33317

3. The information authorized for release may include sensitive records which may include, but are not limited to Sexually Transmitted Diseases (STDs), the human immunodeficiency virus (HIV), also known as Acquired Immune Deficiency Syndrome (AIDS), substance abuse, drug use and/or mental health information

Signature _____ **Date:** _____

Patient or Legal Representative

PATIENTS RESPONSIBILITIES (Please initial each item)

APPOINTMENT AND STATUS

_____ 1. I will inform the Front Desk staff if my address, phone number, employment and/or employment position changes.

_____ 2. I will keep appointments and if I cannot make my appointment, I will contact the Front Desk staff with at least 24 hours' notice.

_____ 3. I understand that I can contact the Front Desk staff regarding any appointment issues, MRI referrals, specialist referrals and related paperwork.

_____ 4. I understand that I can request to make an appointment with a Claims Manager to discuss issues regarding my case status, denial, denial of authorization for treatment and/or if I have a new injury.

_____ 5. I am responsible for scheduling my treatment appointments for at least 3 weeks in advance to assure appointment time slot(s) I need.

_____ 6. I understand that I need to leave a voicemail message if I want a callback if the office is closed or if Iam greeted by the answering machine.

_____ 7. I understand that I cannot tell my doctor to put me off work unless he says it is medically necessary.

CLAIM STATUS

_____ 8. I will forward or bring a copy of any correspondence I receive from OWCP/Department of Labor,even after I am discharged or no longer attending therapy at D. O. L. Injury Centers.

_____ 9. I understand that failure to comply with forwarding correspondence can result in a denial of my claimand if my claim is denied for not bringing documents on time, I will be financially responsible for theservices I have received.

_____ 10. I understand that I need to comply with the prescribed therapy and my doctor's instructions in order to achieve maximum results and return to pre-injury status

FORMS

_____ 11. I am responsible for all documents pertaining to my wages, loss time. Mileage reimbursement, medical expense reimbursement and form submissions such as CA-7s to my agency. My provider's office will not engage in matters regarding my wages, pay or related documents. We will not fax any documents to agencies or OWCP.

PRIVACY

_____ 12. I will respect the privacy of others especially of my co-workers by not mentioning to others that Ihave seen someone here at 4FED-HURT nor anything of that nature.

_____ 13. I will treat all personnel patients and visitors with courtesy and respect.

MEDICAL RELEASE AND ASSIGNMENT OF BENEFITS

RELEASE AUTHORIZATION Florida Spine & Sport INC. / DBA DOL Injury Centers/ DBA 4FED-HURT TO ENDORSE CHECKS AND/OR TO SIGN ANY PIECE OF PAPER WHICH WILLENHANCE OR EXPEDITE PAYMENT TO THE PROVIDER FOR SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS and ASSIGNMENT OF BENEFITS/AUTHORIZATION TO PAY.

Know by all these present that: The undersigned has made, constituted and appointed, and by these presents does herby make, constitute and appoint Florida Spine & Sport /DBA DOL Injury Centers/ DBA 4FED-HURT, and any of its dulyauthorized agents and employees as and to be the undersigned's true and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders which are made payable to the undersigned aloneor to the undersigned and the said Florida Spine & Sport DBA DOL Injury Centers/ DBA 4FED-HURT., which checks, drafts or money orders are made payable for services which have been made by Florida Spine & SportDBA DOL Injury Centers/ 4FED-HURT., at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft of money order.

Furthermore, the undersigned allows Florida Spine & Sport DBA DOL Injury Centers/ 4FED-HURT., or any of its agents to sign any paper that will be necessary to enhance, expedite and/or allow payment to said provider.This may include affidavits of non-ownership of vehicles, insurance forms and other statements.

The undersigned by these presents does give and grant the said Florida Spine & Sport DBA DOL Injury Centers/ DBA 4FED-HURT as the attorney the full power and authority to do and perform all and every act whatsoeverrequisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said checks are concerned as well as any other document.

MEDICAL RELEASE

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services, or supplies pertaining to me to release true copies of same to Florida Spine & Sport DBA DOL Injury Centers/ 4FED-HURT or any insurer providing coverage to mi in connection with the processing of any claim forbenefits made by me or by the assignee herein. A photocopy of this document shall be as binding as an original signature page.

The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of their presents. to make medical benefits payments otherwise payable to me for services rendered by Florida Spine & Sport DBA DOL Injury Centers/ DBA 4FED-HURT, but not to exceed the charges of those services, payable to and mailed to:

AS S I GNM E NT OF B E NE F I T S

I,_____Hereby authorize _____OWCP_____

(Name of Insured/Patient) (Name of Insurance Carrier)

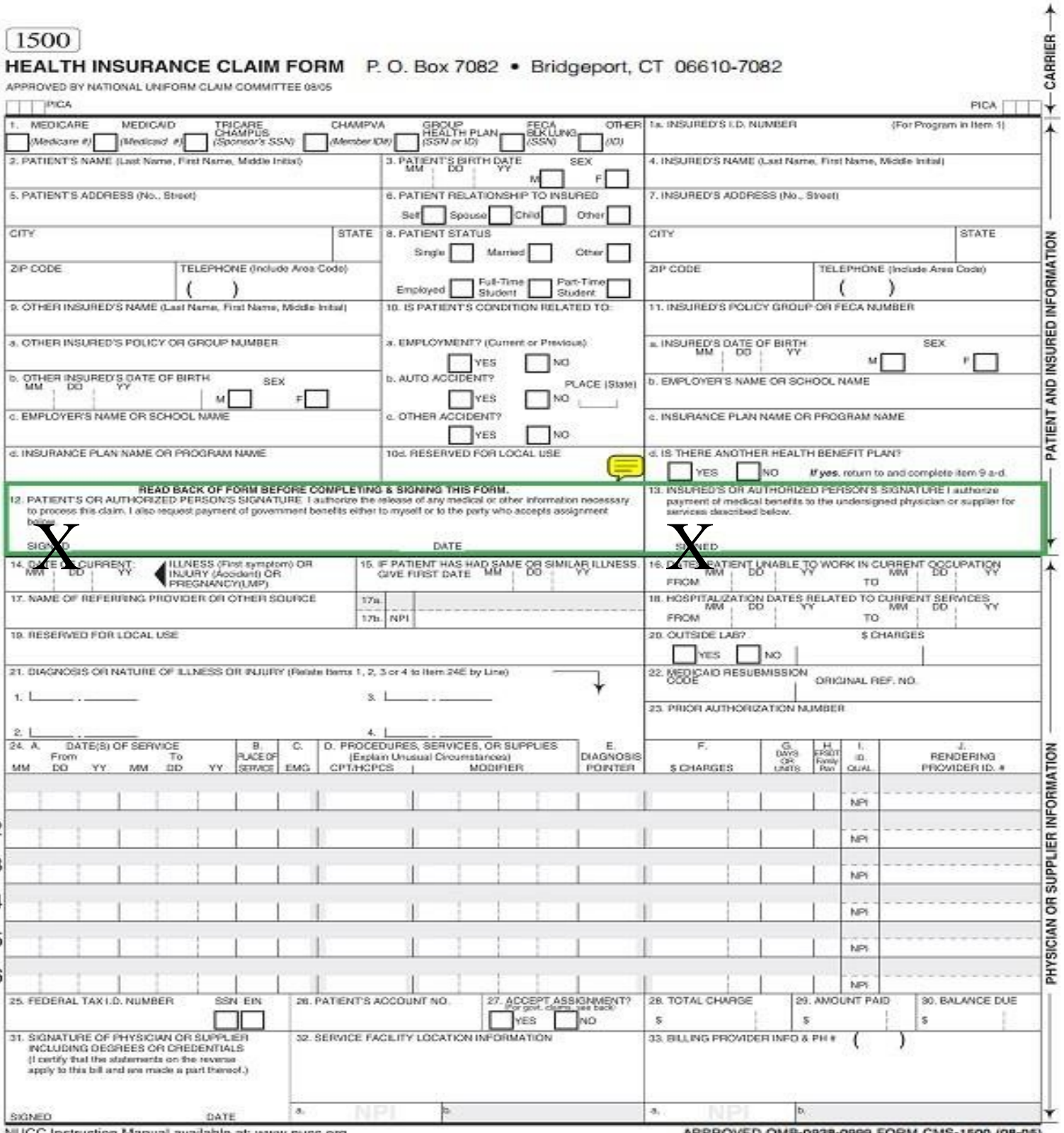
I hereby instruct the insurance carrier that in the event the subject medical benefits are disputed for any reason, including medical reasonableness and/or necessity that the amount of unpaid benefits claimed by Florida Spine & Sport DBA DOL Injury Centers/ DBA 4FED-HURT is to be set aside and not disbursed until the dispute is resolved. Furthermore, I hereby irrevocably assign to Florida Spine & Sport DBA DOL Injury Centers/ DBA 4FED-HURT the rights and benefits and any and all causes of action resulting from nonpayment under any policy of insurance, indemnity agreement, or any other collateral source asdefined in Florida Statutes for any service and or charges provided by Florida Spine & Sport DBA DOL Injury Centers/ DBA 4FED-HURT

IN WITNESS WHEREOF the undersigned have here unto set their hands, this_____day of_, 20_____.

_____ _____

PATIENT NAME (PLEASE PRINT) PATIENT SIGNATURE

(Please ONLY sign and date on the "X" below)



1500

HEALTH INSURANCE CLAIM FORM P. O. Box 7082 • Bridgeport, CT 06610-7082

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

X

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

X

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

MS-07-139

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

Notice of Privacy Practices

YOU DO NOT NEED TO RESPOND TO THIS NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

AHCA'S Responsibilities

The Agency for Health Care is required by law to maintain the privacy of your protected health information in our custody. We must provide you with notice of our legal duties and privacy practices with respect to your health information. We must also follow the terms of this notice.

How AHCA Uses and Safeguards your Health Information

If you are a Medicaid/MediKids recipient, we use your health information to pay for your health services and to operate the Medicaid program. We may also use your health information to tell you about treatment alternatives or other health-related benefits and services.

The following are some examples of how we may use your health information:

Your doctor may send us a claim to pay. The claim includes information that identifies you and the type of care you received. We may share your information with a company that reviews hospital records to check on the quality of care that you received. We may send appointment reminders for Child Health Check-Up services. **AHCA may also use and disclose your health information as permitted by law, such as:**

To entities outside the agency for purposes directly connected with the administration of the State Medicaid plan.

In responding to public emergencies, access to your health information may be granted to persons or agency representatives who are subject to standards of confidentiality comparable to those of AHCA. Such other agencies may include the Federal Emergency Management Agency (FEMA) or the Centers for Disease Control (CDC).

Where disclosure would assist in determining eligibility for benefits, amount of medical assistance payment or otherwise assists the agency in the administration of the Medicaid program.

To the confidential Florida abuse hotline in order to report abuse, neglect and/or domestic violence as per criteria and conditions imposed on the agency by law.

For health oversight activities and/or administration of the Medicaid program, such as inspections, investigations, and audits. To conduct research to benefit the Medicaid program. For purposes of treatment, payment, or our operations and as otherwise required by law.

Other uses or disclosures of your protected health information require your or your personal representative's written authorization. For example, we will not use or disclose psychotherapy notes without your writtenauthorization or as allowed by law. We will not use or discloseyour protected healthinformationfor marketing purposes without your written authorization and we will not sell your protected health information without your written authorization. We also are prohibited by law from using or disclosing genetic information for insurance underwriting purposes. At any time, you may revoke authorizations in writing. If you cannot give your authorization due to an emergency, we may release your health information if it is in your best interest.

You have the following rights with respect to your protected health information:

To see or obtain a copy of your health information that is maintained by AHCA. We may not be able to provide health information that includes psychotherapy notes, is part of a legal case, or is otherwise excluded from disclosure by law. We may charge a copying fee.

To request that we amend health information we maintain that you believe is incorrect or incomplete.

To request a list of disclosures we have made of your health information. The list may not include disclosures authorized by you, disclosures for treatment, payment and health care operations, or other disclosures permitted by law.

To request that we contact you at a different address or phone number, if contacting you about your health information at your present location would endanger you. To request that we limit the use and disclosure of your health information. We are not required to agree to your request. To request another paper copy of this notice.

To opt-out of fundraising communications from us should the agency ever engage in fundraising. To receive a notification from us following a breach of your unsecured protected health information.

Contact Information

If you have any questions, wish to make a request regarding your health information, or would like another paper copy of this notice, please contact the AHCA Medicaid office in your area at the telephone number listed below. We may ask you to make the request in writing.

1	Pensacola: (850) 595-2300	4	Jacksonville: (904) 798-4200	8	Ft. Myers: (239) 335-1300
2A	Panama City: (850) 767-3400	5	St. Pete: (727) 552-1900	9	WestPalmBeach:(561)712-4400
2B	Tallahassee: (850) 412-4002	6	Tampa: (813) 350-4800	10	Ft. Lauderdale: (954) 958-6500
3A	Gainesville: (386) 462-6200	7	Orlando: (407) 420-2500	11	Miami: (305) 593-3000
3B	Ocala: (352) 840-5720				

FILING A HIPPA COMPLAINT

If you believe your privacy rights have been violated by AHCA or one of its employees, you may file a complaint with AHCA and/or the Secretary of the Department of Health and Human Services at the addresses below. You will not be retaliated against for filing a complaint.

Privacy Officer
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 4
Tallahassee, Florida 32308
(850) 412-3960

Secretary
Department of Health and HumanServices
200 Independence Ave.SW
Washington, D.C. 20201
(800) 368-1019

Future Changes to the Notice of Privacy Practices

AHCA reserves the right to change the terms of this notice and to make new notice provisions effective for all protected health information that we maintain. If we make a material revision to this notice, we will send a revised copy of the notice to recipient households within sixty (60) days of the revision.

Who receives the Notice of Privacy Practices?

We send this notice to every recipient household. This notice applies to all Florida Medicaid recipients.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand them. I understand that this form will be placed in my patient chart and maintained for six (6) years.

Signature (Patient/Guardian) _____ Date _____

ELECTRONIC COMMUNICATION CONSENT FORM

You have the option of sending and receiving electronic communication to and from Fed-Hurt and for attending sessions remotely (over-the-phone or via telehealth (video)). Fed-Hurt would like to ensure that you understand the risks, benefits, limitations, and requirements of using electronic communication (including telehealth). Information gathered from electronic communication with your FED-HURT provider may be used for diagnosis, treatment, therapy, follow-up and/or education.

I understand that:

- The use of electronic communication that involves information being sent, received, or stored electronically carries a level of security risk. FED-HURT recommends, and in some cases requires, the use of secure (encrypted) forms of communication to minimize the security risk, though I understand that this does not always guarantee or eliminate the risk of a potential breach of information.
- Without electronic consent, communication and continuum of care may be delayed and interrupted for client and their providers.
- These communications may include appointment reminders, test results, treatment updates, surveys, and other important information related to my care. Since text messages do not meet privacy standards, they cannot include private health information. Please leave any clinical details in a voicemail or wait to have a direct conversation with the provider.

By signing or providing verbal consent of this form, I acknowledge that I have read, understood, and have discussed with my provider the risks, benefits, and limitations of each form of electronic communication.

Signature: _____

Date: _____