Consent for Medical Treatment

1. **Authorization for Release of Information –** The HIPPA Privacy Rule allows those doctors, nurses, hospitals, laboratory technicians, and other health care providers that are covered entities to use or disclose protected health information, such as x-rays, laboratory and pathology reports, diagnoses, and other medical information for treatment purposes with the patient's authorization. This includes sharing the information to consult with other providers, including providers who are not covered entities, to treat a different patient, or to refer the patient.

2. **Consent for Healthcare Services –** I voluntarily consent to and authorize the rendering of health care services, including routine clinical services, diagnostic procedures, and other services or procedures which my therapist or others holding clinical privileges consider necessary. I am aware that Physical/Occupational Therapy treatment utilizes hands-on techniques which require the therapist to touch my body as part of the therapeutic process. I understand that health care services may be rendered by students or interns under supervision by physical/occupational therapists. I further understand that the practice of medicine is not an exact science and I acknowledge that no promises or guarantees have been made to me regarding treatment or services rendered in this health care facility.

3. **Medicare Certification –** I certify that the information given by me in applying for payment under the Medicare program is correct. I request that payment of authorized benefits be made to the clinic on my behalf for the clinics and therapists charges for which the clinic is authorized to bill in connection with these heath care services.

4. **Financial Agreement –** I understand that there is no guarantee of reimbursement or payment from any insurance company or other payor. I acknowledge full financial responsibility for, and agree to pay, all charges of the clinic and of therapists rendering services not otherwise paid by my health insurance or other payor. All charges are due and payable upon receipt of the bill. If payment is not made within 90 days of the receipt of the bill, a delinquent charge or interest at the maximum legal rate may be added. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I acknowledge and understand that any refund that I may be owed will be forwarded to the address on file with the clinic.

5. **Preauthorization Requirements –** I understand that it is my sole responsibility to obtain all preauthorizations and to comply with all requirements of any insurance or medical/hospital coverage plan upon which I am relying for coverage of the clinics and therapists charges.

6. **Assignment for Direct Payment –** I authorize and direct that payment from any insurance or health care benefits otherwise payable to me for health care services or goods be made directly to the clinic and my therapists. I understand that I am financially responsible to the clinic or my therapists for charges not covered or paid pursuant to this authorization.

7. **Personal Valuables –** I understand that the clinic does not assume responsibility for the loss, damage, or disposal of my personal property or money including but not limited to jewelry, clothing, eyeglasses, contact lenses, hearing aids, prosthetic devices, or any other item while I am a patient at the clinic.

8. **Privacy Act –** I have received a copy of the Notice of Privacy Practices. This Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. I was given the opportunity to review the Notice and ask questions regarding my privacy rights.

I ACKNOWLEDGE I HAVE READ THIS FORM AND UNDERSTAND ITS CONTENTS. I FURTHER ACKNOWLEDGE THAT I AM THE PATIENT, OR PERSON DULY AUTHORIZED EITHER BY THE PATIENT OR OTHERWISE, TO SIGN THIS AGREEMENT, CONSENT TO, AND ACCEPT ITS TERMS.

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SIGNATURE OF PATIENT OR LEGALLY RESPONSIBLE PERSON	NAME (PRINT)
RELATIONSHIP/REASON WHY PATIENT IS UNABLE TO SIGN	DATE AND TIME
WITNESS TO SIGNATURE	NAME (PRINT)