

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give consent for NY Physical Therapy & Wellness, LLC to furnish medical care and treatment necessary and proper in diagnosing or treating his/her physical condition.

Signature of Patient/Guardian

Date

BENEFIT ASSIGNMENT / RELEASE OF INFORMATION

I, hereby assign medical benefits to which I am entitled, including Medicare, private insurance and third party payers to NY Physical Therapy & Wellness. A photocopy of this assignment is information necessary including Medical records, to secure payment.

Signature of patient/Guardian

Date

AUTHORIZATION TO OBTAIN OR RELEASE OF MEDICAL RECORDS FROM MEDICAL PROVIDERS

I hereby authorize NY Physical Therapy & Wellness, LLC to obtain any and all medical records concerning my care from any physician, hospital or health care professional that has provided medical care to me in the past.

I also authorize NY Physical Therapy & Wellness, LLC practice to release any and all medical records concerning my care to any physician, hospital or other health care professional providing care to myself / and or child at anytime.

Signature of Patient/Guardian

Date

ACKNOWLEDGEMENT FORM

I acknowledge that I have been given a copy of the Practice's "HIPAA Privacy Policy Notice", which describes the Practice's obligations to ensure the privacy of my health information. The HIPAA Privacy Notice also describes how the Practice may use and disclose my health information for treatment, payment and health care operations. I know that I have the right to review the Practice's HIPAA Privacy Notice and to ask questions about it. I understand that the Practice is required to maintain the privacy of my health information in accordance with the terms of its HIPAA Privacy Notice.

I further acknowledge that the Practice can change its HIPAA Privacy Notice in the future and that I can receive a copy of the Practice's current Privacy Notice at anytime.

I understand that I have the right to request that the Practice restrict its uses and disclosures of my health information for treatment, payment or health care operations. If my restrictions are accepted by the Practice, these restrictions will be binding on the Practice. I also understand that the Practice is not required to agree to my requested restrictions.

I do not request any restrictions on the Practice's uses and disclosures of my health information for treatment, payment or health care operations. _____(Initial)

By signing this form, I consent to the Practice's use and disclosure of my health information for treatment, payment and health care operations. I understand that I have the right to revoke this consent at anytime in writing, but if I do, my revocation will not have an effect on any actions the Practice has already taken in reliance of this consent.

Signature of Patient/Guardian

Date

Patient chose not to sign acknowledgement
Reason: _____

Office staff acknowledging patients refusal to sign consent