IMPACT PHYSICAL THERAPY

CONSENT FOR TREATMENT

1. AUTHORIZATION:

A. I hereby authorize Impact Physical Therapy's health care professionals and students to provide such medical care and to administer such treatment, necessary to the named patient or me each time I or the named patient present to an ambulatory care service. Such procedures and treatments may include, Physical Therapy, Occupational Therapy & Speech Therapy. To the extent possible I have been informed of risks and complications that may occur and alternatives that may be available.

B. I acknowledge that no guarantees or assurances have been made to me concerning the results intended from my treatment.

2. MEDICARE PATIENTS:

A. I authorize any holder of medical or other information about me to be released to the Social Security Administration, its intermediaries, carriers and information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts the assignment below.

3. GUARANTEE OF ACCOUNT:

A. For and in consideration of services rendered to (Patient Name) by Impact Physical Therapy. I hereby agree to pay the full bill for all charges which are not paid to Impact Physical Therapy by insurance carriers, Worker's Compensation, No-fault or any balance due which is not covered by insurance or excluded by a co-insurance clause.

4. RELEASE OF INFORMATION:

A. I permit Impact Physical Therapy to disclose all or part of the above patient's medical records to any person, corporation, or agency when required for the collection of benefits or payment of Impact Physical Therapy charges.

5. HIPAA – NOTICE OF PRIVACY ACKNOWLEDGMENT :

A. Impact Physical Therapy has made their Notice of Privacy Practices available to you. Your name, signature, time and date on this cover sheet indicate that you have acknowledged the availability of the Impact Physical Therapy's Privacy Practices and were given the option to receive a copy for your possession. If you have any questions regarding the information set forth in the Impact Physical Therapy's Notice of Privacy Practices, please do not hesitate to contact the Impact Physical Therapy's Privacy Officer: Marc Plawner Tel: (877) 752-9637 or Fax Inquiries to: (732) 605-5963

I confirm that I have read and fully understand the above.

Facility Name:

Patient Name: Patient Signature: _____

Relative/Guardian (if not patient): _____ _____
(Signature) (Print name)

Relationship (if signed by person other than patient) _____

(If Required) Interpreter: _____ _____
(Signature) (Print name)

Rep Name (Witness): _____ _____ _____
(Signature) (Print name) (Date)