CONSENT TO PHYSICAL THERAPY EVALUATION AND TREATMENT

I hereby consent to evaluation and/or treatment of my condition by licensed physical therapist, Janice Ying, PT, DPT, OCS (CA#: 36919)

The physical therapist has fully explained to me the nature and purposes of the procedures, evaluation and course of treatment, and has witness my signature of this consent in his or her presence. The physical therapist has informed me of expected benefits and possible complications or discomfort, which may result from skilled physical therapy care. In addition, the physical therapist has explained to me the risks of receiving no treatment.

The physical therapist has explained that there is not guarantee that the proposed course of treatment will improve my condition and that is possible, although unlikely, that the course of treatment may cause additional pain or discomfort or aggravate my condition. 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.

Patient/relative or guardian _____/_____
Signature (Print Name)

Date _____ _____
(Relationship, if signed by person other than client)

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to the proposed evaluation and treatment have offered to answer any questions and have fully answered all such questions. I believe that the patient/relative/guardian fully understands what I have explained and answered.

Physical therapist_____ Date_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that I have received Notice of Privacy Practices for protected health information.

Date: _____ Name of Patient: _____
Print Name

_____
Signature of Patient/Personal Representative

Financial Responsibility:
In consideration for services to be provided, I consent to pay Professional Physical Therapy all amounts that are due or owing for services provided and not paid by Medicare, a third party insurance plan or payor, or other source on my behalf for services so rendered. In the event it is necessary to refer this account to a collection agency or an attorney, the undersigned further agrees to pay all reasonable costs of collection, including reasonable attorney fees.

Signature of Patient or Guardian: _____ Date ____/____/_____

Notice of Privacy Practices:
▫ I hereby acknowledge that I have been offered a copy of the Notice of Privacy Practices. (You have the right to refuse to sign this acknowledgement if you so choose.)

Signature of Patient or Guardian: _____ Date ____/____/_____