



1. RELEASE OF INFORMATION:

I authorize Oakdale Physical Therapy & Fitness, or its legal representative, to release any information regarding the diagnosis and treatment rendered to me during episode of care, to my insurance company or its representative, and to my primary and referring physicians. This releases Oakdale Physical Therapy & Fitness from all legal responsibility for the release of the records, while in compliance with HIPPA regulations and privacy laws.

2. CONSENT FOR MEDICAL CARE AND ASSUMPTION OF RISK:

I have been informed that participation in Physical Therapy (PT): may include exercises for strengthening, conditioning, flexibility, and agility and may involve the use of equipment. Such participation has potential mental/physical risks.

During my treatment at Oakdale Physical Therapy and Fitness I agree to the following:

- My participation in PT is strictly voluntary.
- My participation in each exercise and activity is voluntary and I may choose to limit my participation in any activity at any time.
- I am personally responsible for my own safety during PT. I will monitor and pace myself in a manner that is safe while still actively engaging in each activity.
- I will advise my Physical Therapist of any changes in my physical or mental health prior to participation in each session. I understand that failure to provide this information may have a negative effect with my treatment.
- My Physical Therapist is available to answer any questions that I might have regarding my participation in PT and failure to ask these questions may negatively impact my treatment.
- I will seek further direction or explanation for anything that I do not fully understand, or that causes me concern.

I hereby accept the responsibility for any harm, injury, or damage that may result from my participation in PT. I hereby waive, release and agree to hold harmless Oakdale Physical Therapy and Fitness for any claim arising out of any injury to me.

3. ASSIGNMENTS OF INSURANCE BENEFITS AND PATIENT RESPONSIBILITY

By signing this form, I authorize Oakdale Physical Therapy and Fitness to submit medical claims on my behalf to my insurance provider. I understand and acknowledge that submission of claims is not a guarantee of payment. I understand that it is my responsibility to notify Oakdale Physical Therapy & Fitness of any changes to my insurance carrier or coverage as soon as possible. Any failure to report such changes will result in the patient being financially responsible for any lapse in coverage or authorization. If for any reason my carrier does not cover any and/or all of my physical therapy treatments, I agree that I am responsible for the payment of the entire amount. These include deductible, co-payment, cost-share, and/or non-covered benefits. In the event of default, I shall be responsible for all costs of collection and reasonable attorney fees. Furthermore, I authorize payment of medical benefits to which I am entitled, to Oakdale Physical Therapy & Fitness for medical services rendered. I understand that payment is due at the time of service. We accept cash, personal checks, debit and major credit cards. We reserve the right to charge a \$35 insufficient funds fee for returned checks. **We DO NOT accept Medicaid insurance at this time.**

4. NEW YORK STATE REQUIRMENTS:

New York State law mandates a physician’s prescription for physical therapy treatments for Medicare, Worker’s Compensation, and No Fault. Each is valid for only four (4) weeks from the date listed on the prescription. I understand that it is my responsibility to obtain a new prescription at the end of the specified time period. If I fail to obtain an updated prescription, I understand that I will be responsible for payment of services not covered by my carrier. For some insurance carriers, direct access is allowed. Medicare, Worker’s Comp and No Fault are excluded from Direct Access. If your insurance company allows direct access, you will have 10 visits or 30 days, whichever comes first, before you will be required to obtain a physician’s prescription.

5. PERSONAL VALUABLES:

I understand that Oakdale Physical Therapy & Fitness shall not be held liable for the loss or damage to any personal property. I have read this waiver and acknowledge that I am signing this document of my own free will, with full knowledge of the risks being assumed. This waiver will remain in effect until the 31st of December of the current year.

Printed Name of Patient

Signature of Patient or Guardian

Date



TO OBTAIN AND RELEASE MEDICAL INFORMATION:

This signed document, copy of same, will authorize you to furnish Oakdale Physical Therapy & Fitness, or its representative, any or all information in your possession regarding the above-named patient’s condition while under your care or treatment, including the history obtained, diagnostic imaging (i.e.: x-ray, MRI, etc...) (includes obtaining copy of original films/discs), physical and laboratory findings, diagnosis and prognosis (including copy of No-Fault/Worker’s Compensation File).

OFFICE USE ONLY				
<input type="checkbox"/> OP REPORT	<input type="checkbox"/> MRI	<input type="checkbox"/> XRAY REPORT	<input type="checkbox"/> CT SCAN	<input type="checkbox"/> OTHER _____

Patient’s printed name: _____ DOB: _____

Patient’s signature: _____ Date: _____

HIPAA CONSENT: Health Insurance Portability and Accountability Act

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice also contains a patient rights section describing your patient rights under the law. You have a right to review this notice before signing the consent. The terms of the notice may change, and if this should occur, you may receive a revised copy by contacting the office. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, or healthcare operations. You have a right to revoke this consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in relation to you on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

1. Protected health information may be disclosed or used for treatment, payment, or health care operations.
2. The practice has a Notice of Privacy Practices and the patient has the opportunity to review this notice.
3. The practice reserves the right to change the notice of privacy practices.
4. The patient has the right to request restricted use of their information, but the practice does not have to agree to those restrictions.
5. The patient may revoke this consent in writing at any time and all future disclosures will then cease.

The patient also understands that Oakdale Physical Therapy & Fitness has adopted the following policies:

1. Patient information will be kept confidential except as necessary to provide services or to ensure that all administrative matters relating to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers and health insurance payers as is necessary and appropriate for your care. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. We sometimes remind patients of their appointments as a courtesy. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. I have read and consent to the assumption of risk and release and the HIPAA practices adopted by Oakdale Physical Therapy & Fitness. I understand that non-identifying patient data may be used in research and/or publication and consent to such use. This consent will remain in effect until the 31st of December of the current year.

I understand that I have the right to obtain a copy of Oakdale Physical Therapy & Fitness Notice of Privacy Practices.

Printed Name of Patient or Representative

Signature of Patient or Representative