BreakThrough Pediatric Therapy

Patient Information Consent Form

Consent to Physical/Occupational Therapy Evaluation and Treatment

I hereby consent to the evaluation and treatment of my condition by a licensed physical and/or occupational therapist employed by BreakThrough Physical Therapy, Inc. The therapist will explain the nature and purposes of these procedures, evaluation, and course of treatment. The therapist will inform me of expected benefits and complications, and any discomforts, and risk that may arise, as well as alternatives to the proposed treatment and the risk and consequences of no treatment.

Assignment of Benefits and Insurance Proceeds

I authorize payment of medical benefits to BreakThrough Physical Therapy, Inc. for services rendered. BreakThrough Physical Therapy, Inc. will make reasonable effort to collect insurance proceeds by completing insurance forms and sending the forms to the insurance company. Completion of such forms and/or the acceptance of assignment of insurance benefits does not relieve the undersigned of the obligation to pay the amount owed for physical therapy.

Patient Information Consent Form (HIPAA)

I have read and fully understand Breakthrough Physical Therapy, Inc.'s Notice of Information Practices. I understand that Breakthrough Physical Therapy, Inc. may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of service provided, and any administrative operations related to treatment or payment. I understand that I have the right to request restrictions, in writing, regarding how my personal health information is used and disclosed for treatment, payment, and administrative operations. I also understand that Breakthrough Physical Therapy, Inc. will consider requests for restrictions on a case by case basis, but is not required to oblige to such requests.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in BreakThrough Physical Therapy, Inc.'s Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time, at which point Breakthrough Physical Therapy, Inc. has 30 days to respond to my request.

Release of Information

I hereby authorize the release of information necessary to file claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

Designated Individuals Authorization

I, _____, hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties will be verified by photo ID before the release of any information. If none, please print "none" below.

Authorized Designees:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

I have read and understand the above consents, assignment of benefits, release of information, and designated individuals authorization above.

Patient Signature _____ Date_____

LATE CANCEL / NO SHOW POLICY

Please call our office if you cannot come to an appointment already scheduled. If you do not call at least 6 hours (during business hours) prior to your appointment time, there will be a **$25 late cancel fee.** Failure to call or show for an appointment will result in a **$50 No Show fee.**

Patient Signature _____ Date_____