SOUTHEASTERN PHYSICAL THERAPY
Patient Consent Form

Patient Consents:

(initial) _____I consent to be evaluated and treated by Southeastern Physical Therapy by a licensed physical therapist, physical therapist assistant, or an occupational therapist.

(initial) _____I grant permission to Southeastern Physical Therapy to release my medical records to any outside vendors for the purposes of obtaining equipment to aide in my physical therapy treatment.

(initial) _____PAYMENT AUTHORIZATION & ASSIGNMENT: I hereby authorize this physician/clinic to release any information required in the course of my examination or treatment to other healthcare providers. In the case of Medicare, I authorize the release to the Health Care Financing Administration and its agent any information needed to determine benefits payable for related services. I authorize direct assignment of my benefits payable under my insurance to this facility.

FINANCIAL RESPONSIBILITY: I understand that I am responsible for any amounts not covered by my insurance company. I understand that services received at Southeastern Physical Therapy are billed in a clinical setting physical therapy services. This may affect how my insurance pays and any relating precertification, co-pay, co-insurance, out of pocket amount or deductible. Southeastern Physical Therapy recommends for you to contact your insurance company to verify coverage-including visit limits or pre-certification.

Copays are due at time of service. If you cannot afford to pay your copay at each visit, you may fill out a payment plan and pay an amount that you can afford on a monthly basis. If you would like to set up a payment plan, please let us know and we will be happy to assist you with this.

_____ _____ _____

Patient or Guardian Signature Date Employee Witness

PRIVACY PRACTICES

Southeastern Physical Therapy cares about your privacy. Southeastern Physical Therapy is committed to protecting your medical information. We do create a record of your treatment to provide you with outstanding care and compliance with legal documentation. We may utilize this information to provide you your medical care or to disclose to bill and receive payment for the services we render; or for the preauthorization needed for your services. We may release information requested by your workers compensation carrier, wc nurse, or wc claim adjuster as well as released to any court order, subpoena, warrant, summons or similar process. We may also use this information to contact you with appointment reminders or to tell you about possible alternative treatment options that may be of interest to you. You also have the right to inspect and or receive your medical information that may be released to above mentioned parties. A written request is required to release your information to yourself or anyone you have authorized. A fee may be incurred for the information requested. Anyone listed as responsible party on your paperwork is able to request your information. You have a right to submit a written restriction or limitation on your account on information that is disclosed. In this request you must list what information is limited and to whom it is to apply. If you believe your privacy has been violated please contact our Operations Director at 828-274-2188. We will try to accommodate all reasonable requests.

_____ _____ _____

Patient Signature or Legal Representative, Patient Printed Name Date

To be signed if patient is under 18 years of age

We encourage parent involvement in treatment; however, please sign below if the patient is under the age of 18 and you give consent for Southeastern Physical Therapy to treat your child in the absence of a parent/guardian.

Parent/Guardian Signature_____ Date _____.