

Consent For Treatment

I hereby agree and give my consent for medical treatment of my physical condition. I authorize release of any medical information needed to process my claim. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes that occur with regard to my insurance policy. I authorize release of payment directly to Dynamic Physical Therapy regardless of whether benefits are deemed to be in-network or out-of-network. Should I default on my financial responsibility and monetary collection is necessary, I will be responsible for collection costs that are incurred.

Patient/Parent/Guardian Signature: _____ Date: _____

HIPAA Rights and Responsibilities

I acknowledge that I have seen the "Notice of Privacy Practices" and understand that I may ask questions about this policy at any time.

Patient/Parent/Guardian Signature: _____ Date: _____

Please indicate any family members we may speak with regarding your diagnosis, treatment plan, or prognosis.

May we leave a message on your answering machine? Yes No

Child/Adolescent Protection Policy (For patients < 18 years old)

It is the policy of Dynamic Physical Therapy to release minors only to the care of the following individuals following completion of their physical therapy visit.

Patient/Parent/Guardian Signature: _____ Date: _____