
ACKNOWLEDGEMENT OF RECEIPT / OFFER OF NOTICE OF PRIVACY PRACTICES

Dear Patient,

Federal law requires us to provide you with a Notice of Privacy Practices, which is our explanation of how we use and disclose your health information, and to ask you to acknowledge that you have received the Notice.

Your Rights as a Patient:

1. You have the right to copy and inspect your medical records. There may be a charge for this copying.
2. You may request in writing an amendment of information contained in your medical records.
3. You have the right to file a complaint.
4. You have the right to restrict the use and disclosure of your medical information.
5. You have the right to request a history or accounting of the use of your medical records

You have the right to review our notice before signing this acknowledgement, and, if you have any questions, to ask for an explanation of any part of the notice, or any other aspects of our use and disclosure of your health information. The terms of our Notice may change as the law and our practices change.

If we change our Notice, we will have revised copies available to you when you visit us, and also send you a revised copy upon your request. We appreciate you signing this form, which acknowledges that you have received, or have been offered and refused, a copy of our Notice.

Patient Name: _____ Date: _____
(Parent or Legal Guardian must sign if patient is under 18 years of age)

Patient / Representative Signature: _____ Date: _____

CANCELLATION POLICY

I understand that my doctor has prescribed therapy for me and that physical therapy is an on going process, which requires regular attendance to be optimally effective. I understand that if I am late for an appointment, I may have to reschedule my appointment or may have to accept an abbreviated treatment for the day. I understand that if I am a no show for two consecutive appointments, Outpatient Physical Therapy & Rehabilitation Services has the right to discharge me from care for being non-compliant with my physician's orders.

I understand and agree that Outpatient Physical Therapy & Rehabilitation Services requires 24-hour advance notice of cancellation. If I fail to give 24-hour notice of cancellation or fail to show up for an appointment, I may be subject to a \$25 charge (which is not covered by insurance.)

Signature: _____ Date: _____
(Parent or Legal Guardian must sign if patient is under 18 years of age)

RELEASE OF INFORMATION, CONSENT FOR TREATMENT, AND BENEFITS

I hereby consent to physical therapy services, evaluation and treatment of Outpatient Physical Therapy & Rehabilitation Services as directed by my physician and/or physical therapist.

I authorize my insurance benefits to be paid directly to Outpatient Physical Therapy & Rehabilitation Services. I am financially responsible for any remaining balance due. If you need to arrange a payment plan, please contact our business office at 425-413-4405. I authorize the physical therapist to release/exchange any information with my physician and insurance company.

Signature: _____ Date: _____
(Parent or Legal Guardian must sign if patient is under 18 years of age)