PATIENT NAME: _____ DATE OF BIRTH: _____

1. CONSENT FOR THERAPY SERVICES

THE PURPOSE OF PHYSICAL AND OCCUPATIONAL THERAPY IS TO TREAT DISEASE, INJURY AND DISABILITY BY EXAMINATION, EVALUATION, DIAGNOSIS, PROGNOSIS AND INTERVENTION THROUGH THE USE OF THERAPEUTIC PROCEDURES, MOBILIZATION, MASSAGE, EXERCISES, AND PHYSICAL AGENTS TO AID THE PATIENT IN ACHIEVING THEIR MAXIMUM POTENTIAL WITHIN THEIR CAPABILITIES.

RESPONSE TO PHYSICAL AND OCCUPATIONAL THERAPY INTERVENTION VARIES FROM PERSON TO PERSON; HENCE, I UNDERSTAND IT IS NOT POSSIBLE TO ACCURATELY PREDICT MY RESPONSE TO A SPECIFIC MODALITY, PROCEDURE, OR EXERCISE PROTOCOL. I FURTHER UNDERSTAND THAT IT IS MY RIGHT TO DECLINE ANY PART OF MY TREATMENT AT ANY TIME BEFORE OR DURING TREATMENT, SHOULD I FEEL ANY DISCOMFORT OR PAIN OR HAVE OTHER UNRESOLVED CONCERNS. IT IS ALSO MY RIGHT TO ASK MY PHYSICAL OR OCCUPATIONAL THERAPIST ABOUT THE TREATMENT THEY HAVE PLANNED BASED ON MY INDIVIDUAL HISTORY, THERAPY DIAGNOSIS, SYMPTOMS, AND EXAMINATION RESULTS. CONSEQUENTLY, IT IS MY RIGHT TO DISCUSS THE POTENTIAL RISKS AND BENEFITS INVOLVED IN MY TREATMENT.

I HAVE READ THIS CONSENT FORM AND UNDERSTAND THE RISKS INVOLVED IN PHYSICAL AND OCCUPATIONAL THERAPY AND AGREE TO FULLY COOPERATE, PARTICIPATE IN ALL PHYSICAL AND OCCUPATIONAL THERAPY PROCEDURES, AND COMPLY WITH THE ESTABLISHED PLAN OF CARE.

2. AUTHORIZATION & BENEFIT ASSIGNMENT; FINANCIAL RESPONSIBILITY

I ASSIGN AND TRANSFER TO AXES PHYSICAL THERAPY ALL INSURANCE AND OTHER BENEFITS AND PROCEEDS, INCLUDING MEDICARE AND MEDICAID BENEFITS AND PROCEEDS, TO WHICH I AM OR MAY BECOME ENTITLED AS A RESULT OF AXES PHYSICAL THERAPY'S CHARGES FOR PRODUCTS AND SERVICES DELIVERED TO ME OR THE PERSON NAMED ABOVE FOR WHOM I AM THE LEGAL GUARDIAN OR AUTHORIZED REPRESENTATIVE. THIS TRANSFER AND ASSIGNMENT IS MADE AND SHALL BE RE-MADE AS OF THE DATES ON WHICH EACH BENEFIT BECOMES PAYABLE TO ME. IN CONNECTION WITH THIS ASSIGNMENT OF BENEFITS, I HEREBY TRANSFER AND ASSIGN TO AXES PHYSICAL THERAPY ANY RIGHT, TITLE AND INTEREST THAT I HAVE OR MAY HEREAFTER HAVE TO COLLECT FROM ANY INSURER OR PAYER, INCLUDING MEDICARE AND MEDICAID, AND AUTHORIZE AXES PHYSICAL THERAPY TO SUBMIT A CLAIM TO SUCH INSURER OR PAYER ON MY BEHALF.

I AGREE TO PAY ANY APPLICABLE CO-PAYMENTS AT THE TIME OF SERVICE AND COINSURANCE AND/OR DEDUCTIBLES AS AGREED BETWEEN AXES PHYSICAL THERAPY AND ME. I UNDERSTAND THAT MY INSURANCE BENEFITS MAY NOT COVER ALL CHARGES AND THAT I AM RESPONSIBLE FOR THOSE CHARGES NOT COVERED BY MY HEALTH INSURANCE OR THIRD PARTY PAYER. I UNDERSTAND AND AGREE THAT IF I FAIL TO MAKE ANY OF THE PAYMENTS FOR WHICH I AM RESPONSIBLE IN A TIMELY MANNER, I WILL BE RESPONSIBLE FOR ALL COSTS OF COLLECTING MONIES OWED, INCLUDING COURT COSTS, COLLECTION AGENCY FEES AND ATTORNEY FEES. IF I RECEIVE DIRECT PAYMENT FOR PRODUCTS AND/OR SERVICES PROVIDED TO ME BY AXES PHYSICAL THERAPY FROM AN INSURER OR OTHER PAYER, I WILL HOLD SUCH PAYMENT IN TRUST FOR THE BENEFIT OF AXES PHYSICAL THERAPY AND I WILL PROMPTLY (A) ENDORSE TO AXES PHYSICAL THERAPY THE CHECK PROVIDER BY SUCH PAYER, OR (B) PAY AXES PHYSICAL THERAPY THE FULL AMOUNT OF SUCH PAYMENT MADE TO ME BY SUCH PAYER.

THE ABOVE MAY NOT APPLY FOR THOSE PATIENTS THAT ARE CONSIDERED WORKER'S COMPENSATION BENEFICIARIES. HOWEVER, I UNDERSTAND THAT IF I CLAIM WORKER'S COMPENSATION BENEFITS AND SUCH BENEFITS ARE SUBSEQUENTLY DENIED, I MAY BE HELD RESPONSIBLE FOR THE TOTAL AMOUNT OF CHARGES FOR SERVICES RENDERED TO ME.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO NOTIFY AXES PHYSICAL THERAPY OF ANY CHANGE IN MY INSURANCE. I UNDERSTAND THAT THIS ASSIGNMENT OF BENEFITS WILL REMAIN IN EFFECT UNTIL REVOKED BY ME (OR MY LEGALLY AUTHORIZED REPRESENTATIVE) IN WRITING.

3. AUTHORIZATION TO RELEASE INFORMATION

I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE CENTERS OF MEDICARE & MEDICAID SERVICES OR ANY OTHER THIRD-PARTY PAYER WHO IS RESPONSIBLE FOR MY INSURANCE BENEFITS AND THEIR AGENTS ANY INFORMATION NEEDED TO DETERMINE THE BENEFITS PAYABLE FOR RELATED PRODUCTS AND SERVICES FURNISHED BY AXES PHYSICAL THERAPY.

4. NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF AXES PHYSICAL THERAPY'S NOTICE OF PRIVACY PRACTICES, WHICH EXPLAINS HOW AXES PHYSICAL THERAPY MAY USE OR DISCLOSE MY PROTECTED HEALTH INFORMATION, SUCH AS TO CARRY OUT TREATMENT, OBTAIN PAYMENT AND FOR ITS HEALTH CARE OPERATIONS.

5. DISCLOSURES TO SPECIFIC FAMILY MEMBERS AND/OR FRIENDS

I DIRECT AXES PHYSICAL THERAPY TO DISCLOSE MY PROTECTED HEALTH INFORMATION TO THE INDIVIDUALS NAMED BELOW FOR PURPOSES OF ALLOWING THESE INDIVIDUALS TO PARTICIPATE IN MY CARE AND TO UNDERSTAND MY HEALTH CONDITION AND TREATMENT OPTIONS:

NAME: _____ RELATIONSHIP: _____
NAME: _____ RELATIONSHIP: _____
NAME: _____ RELATIONSHIP: _____

UNLESS I OBJECT, I UNDERSTAND THAT EVEN IF AN INDIVIDUAL IS NOT IDENTIFIED ABOVE, AXES PHYSICAL THERAPY MAY EXERCISE PROFESSIONAL JUDGMENT AND DISCLOSE MY HEALTH INFORMATION TO A FAMILY MEMBER OR FRIEND WHO IS INVOLVED IN MY MEDICAL CARE OR PAYMENT FOR MY CARE, AS PERMITTED BY HIPAA.

6. ATTENDANCE AND CANCELLATION POLICY

I UNDERSTAND THE IMPORTANCE OF CONSISTENTLY ATTENDING MY THERAPY SESSIONS AND ARRIVING PROMPTLY FOR MY APPOINTMENT. I ACKNOWLEDGE THAT I MAY BE RESCHEDULED IF I ARRIVE MORE THAN 15 MINUTES LATE FOR MY SCHEDULED APPOINTMENT. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO SCHEDULE MY THERAPY APPOINTMENTS AND THAT MY SCHEDULED TIMES DO NOT AUTOMATICALLY ROLL INTO FUTURE SESSIONS. I AGREE TO PROVIDE AT LEAST 24 HOURS' NOTICE WHEN I NEED TO CANCEL OR RESCHEDULE AN APPOINTMENT.

7. PHOTOGRAPHY/VIDEOGRAPHY CONSENT

I UNDERSTAND THAT IN ORDER TO PROTECT THE PRIVACY OF OTHER PATIENTS, FILMING, GOING 'LIVE' ON SOCIAL MEDIA OR TAKING PICTURES IN THE CLINIC OF MY TREATMENT, OR THE TREATMENT OF OTHERS, IS PROHIBITED WITHOUT PRIOR AUTHORIZATION FROM THE CLINIC DIRECTOR.

8. CONSENT TO COMMUNICATE ELECTRONICALLY

BY PROVIDING AXES PHYSICAL THERAPY WITH A TELEPHONE NUMBER FOR A CELLULAR OR OTHER WIRELESS DEVICE AND/OR AN E-MAIL BELOW, I AGREE THAT AUTHORIZED PERSONNEL, INCLUDING MY PHYSICAL OR OCCUPATIONAL THERAPIST OR AXES PHYSICAL THERAPY SERVICE PROVIDERS, MAY USE THE PROVIDED TELEPHONE NUMBER OR E-MAIL FOR SCHEDULING/APPOINTMENT REMINDERS, BILLING OR PAYMENT INFORMATION, HOME EXERCISE PROGRAMS, SURVEYS AND EDUCATIONAL/INFORMATIVE CONTENT AS IT RELATES TO MY CONDITION. I UNDERSTAND AND AGREE THAT AXES PHYSICAL THERAPY AND ITS AGENTS, REPRESENTATIVES, OR OTHER SERVICE PROVIDERS AS WELL THEIR RESPECTIVE AGENTS AND CONTRACTORS, INCLUDING ANY BILLING OR ACCOUNT MANAGEMENT COMPANIES AND/OR DEBT COLLECTORS MAY CONTACT ME AT THE PROVIDED TELEPHONE NUMBER(S) WHICH COULD RESULT IN STANDARD DATA AND TELEPHONE CARRIER CHARGES. I EXPRESSLY CONSENT THAT THESE METHODS OF CONTACT MAY INCLUDE USING PRE-RECORDED AND ARTIFICIAL VOICE MESSAGES, TEXT, EMAIL, (IF AN EMAIL ADDRESS HAS BEEN PROVIDED) AND/OR THE USE OF AN AUTOMATIC DIALING DEVICE, AS APPLICABLE. THIS CONSENT IS NOT A CONDITION OF RECEIVING SERVICES FROM AXES PHYSICAL THERAPY. BY PROVIDING A CELL PHONE NUMBER OR EMAIL BELOW, I CONSENT TO THE ABOVE DESCRIBED USE AND CONTACT:

CELL PHONE NUMBER: _____

EMAIL: _____

SIGNATURE FOR CONSENT

BY MY SIGNATURE BELOW, I ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND AND AGREE TO THE TERMS AND CONDITIONS CONTAINED IN SECTIONS 1 THROUGH 8 ABOVE.

PRINTED NAME OF PATIENT/GUARDIAN/RESPONSIBLE PARTY: _____DATE: _____

SIGNATURE OF PATIENT/GUARDIAN/RESPONSIBLE PARTY: _____

RELATION TO PATIENT: _____