CHRIS PRENTISS PHYSICAL THERAPY

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RELEASE OF INFORMATION

I give consent to Chris Prentiss Physical Therapy PC to disclose or request all or any part of the patients medical record to any person or entity which is or may be liable under a contract to the facility, family member or employer of the patient for all or part of the facilities charge, including, but not limited to physical therapy services, insurance companies, workers compensation / no fault carriers, welfare funds, or the patients employer or any New York State or Federal agency per current rules and regulations. Chris Prentiss Physical Therapy PC has the authority to reject any unreasonable request by an office or institution if such request might violate the patient's right to privacy. I understand that confidentiality of my medical records are protected under state and federal law and that this release gives consent to Chris Prentiss Physical Therapy only and not to any party to whom such information is released.

Patients / Responsible Parties Initials: _____

ASSIGNMENT OF BENEFITS

I hereby assign and set forth to Chris Prentiss Physical Therapy PC sufficient monies and / or benefits to which I may be entitled from governmental agencies, insurance carriers, or others who are financially liable for my medical care to cover the costs of care and treatment rendered to me or my dependent. I request that payment of authorized insurance benefits be made on my behalf directly to Chris Prentiss Physical Therapy PC.

Patients / Responsible Parties Initials: _____

CONSENT TO TREAT

I herby request and consent to Chris Prentiss Physical Therapy PC to perform physical therapy treatment as prescribed by my physician and or recommended by my Physical therapist. I understand and am informed that, as in the practice of medicine, physical therapy treatment may have some risk. I understand that I have the right to ask about these risks and have any questions answered about my condition and treatment at any time during the course of my care. I authorize the physical therapist to provide any additional care or treatment, which is deemed necessary, should during the course of treatment such action be warranted. I understand that following an initial evaluation and appropriate re evaluations, a description of my condition/diagnosis, presenting signs and symptoms, contraindications and precautions to treatment and expected benefits of treatment will be explained to me. I have read and understand this consent and authorize Chris Prentiss Physical Therapy PC (Including Physical Therapist Assistants and physical therapy students in training) to administer treatment under the direction and supervision of the Physical Therapist.

Patients / Responsible Parties Initials: _____

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

Chris Prentiss Physical Therapy PC is committed to preserving the privacy of your personal health information. We have available a detailed notice of privacy practices which explain your rights and our obligations under the law. I acknowledge on this date that a copy of the NOTICE OF PRIVACY PRACTICES has been made available to me.

Patients / Responsible Parties Initials: _____

_____ _____ / _____ / _____

Signature of Patient or Responsible Party Date

_____ _____ / _____ / _____

Received by: (CPPT Team member) Date