

ORTHOPAEDIC MANUAL THERAPY
INDUSTRIAL REHABILITATION
SPORTS MEDICINE



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PATIENT INFORMATION ACKNOWLEDGEMENT FORM

I have read and fully understand Lodi Physical Therapy's Notice of Information Practices. I understand that Lodi Physical Therapy may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.

I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice. I also understand Lodi Physical Therapy will consider requests for restriction on a case by case basis, but does not have to agree to request for restrictions.

I hereby consent to the use and disclosure of my personal health information for purpose as noted in Lodi Physical Therapy's Notice of Information Practices. I understand that I retain the right to revoke the consent by notifying the practice in writing at any time.

PATIENT INFORMED CONSENT

I give my consent for Lodi Physical Therapy to render physical therapy to me based on the evaluation findings and medical diagnosis.

CONSENT FOR TREATMENT TO A MINOR: As parents and/or legal guardian, I authorize Lodi Physical Therapy to treat _____ (minor's name) while am not present.

CONSENT FOR CARE AND TREATMENT: Your physical therapist will complete an evaluation by examination and interview. Your individual treatment program will then be designed. A variety of treatment techniques may be used. I, the undersigned, do hereby agree and give my consent for Lodi Physical Therapy to furnish physical therapy care and treatment that is necessary and proper in evaluating and treating my physical condition.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize Lodi Physical Therapy for furnish information to insurance carriers concerning this treatment and I hereby assign all payments for services rendered.

WORKERS' COMPENSATION CLAIMS: If you claim Workers' Comp. benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered.

CANCELLATION AND NO SHOW POLICY: We require 24 hours advance notice in the event of a cancellation. The charge for cancellation without proper notice is \$40 for a physical therapy visit. This charge will not be covered by the insurance, but will have to be paid by you personally prior to receiving additional treatment.

NON-SUFFICIENT FUNDS: Checks returned to Non-Sufficient Funds may be subject to a \$25 processing fee.

Patient/Guardian/Responsible Party Signature

Patient's Name

Date