DANIEL B. NEFF, DPT PHYSICAL THERAPY

PATIENT NAME______________________________________ BIRTHDATE_______________________

AUTHORIZED REPRESENTATIVE (if patient is a minor)________________________BIRTHDATE_______

ADDRESS_____________________________________CITY________________STATE______ZIP_____

PHONE_______________________________________CELL____________________________________

EMAIL ADDRESS____

PRIMARY CARE PHYSICIAN ______________________________PRACTICE NAME _____________

CONSENT FOR TREATMENT

During the course of treatment you may experience and increase in your symptoms. In most circumstances this is a normal part of the recovery process. It's important for you to inform the clinical staff of any difficulties that you are experiencing. You may contact this facility at any time to discuss your status. If you believe that what you are experiencing is out of the ordinary, please contact your physician. Please remember that your care is our top priority. We want to provide you with as much information and education that we can to help expedite your recovery.

In the case of a minor patient (under the age of 18) I hereby authorize Daniel B. Neff, DPT physical therapy to administer physical therapy care deemed necessary for this course of treatment when I am unable to accompany my son/daughter for treatment.

CONFORMATION OF RECIEPT OF NOTICE OF PRIVACY PRACTICE

We are required by federal and state law to provide the privacy practice notice. This notice takes effect 6/1/10 and will remain in effect until we change it. You may request a notice at any time.

This notice complies with the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how my health information (as a patient of this practice) may be used and disclosed, and how I can get access to my individually identifiable health information.

CONSENT FOR RELEASE OF INFORMATION

I authorize release of any medical information concerning my treatment to my insurance company, family physician, referring physician, any physician in the course of care for this issue, any treating facility, my employer, rehab nurse in the case of workers' compensation, adjuster, or the following persons:

Name of persons we may speak to on your behalf (ex: spouse/children/caregivers/friends) ______________________________

FINANCIAL POLICY

We will gladly try to answer any questions related to your insurance, but insurance plans vary considerably and we cannot predict or guarantee what will or will not be covered by your insurance. Your insurance is a contract between you and your insurance as well as your employer if employed. We are not a party to that contract and do not have knowledge of the physical therapy benefits that are contracted in your insurance policy.

We must emphasize that as a physical therapy practice our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, call services are strictly your responsibility from the date services are rendered. Therefore, it is often necessary for you to inquire and explore your benefits with your insurance carrier. Any patient responsibility costs given to you by your insurance company will become your responsibility. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact our business office for assistance in the management of your account.

I have read and fully understand this document set forth by Daniel B. Neff, DPT Physical Therapy.

____________________ ____

Date Signature of Patient or Authorized Representative

Office use only: We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained because:____