Patient Agreements

Please read the following statements and indicate your acknowledgement and/or authorization for each below with your initials:

CONSENT FOR CARE & TREATMENT

_____ I hereby authorize the staff of *CREST PHYSICAL THERAPY* to provide and perform any medical care and treatment deemed necessary or beneficial for my health and wellbeing and appropriate in diagnosing or treating my physical and/or mental condition.

PATIENT PERMISSION TO SHARE PROTECTED HEALTH INFORMATION

_____ I hereby authorize the staff of *CREST PHYSICAL THERAPY* to use or disclose my health information (referred to as "Protected Health Information") to any healthcare provider and/or employee of Crest Physical Therapy. The Protected Health Information (PHI) I am authorizing for use of disclosure is the standard release of information (includes typed diction and therapy notes) and specific information from my chart which includes: _____.

_____ I hereby authorize and request *CREST PHYSICAL THERAPY* to disclose my PHI to the person(s) or institution(s) listed below. I understand that this authorization will expire 180 days from signing, unless an earlier date is indicated: _____.

Authorized Name(s)	Relationship to patient	Authorized Mailing Address

_____ I understand that *CREST PHYSICAL THERAPY* has the right to bill me $1.00 per page for each copy of my PHI.

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

_____ I hereby assign to *CREST PHYSICAL THERAPY* any insurance or other third-party benefits available for healthcare services provided to me. I understand that *CREST PHYSICAL THERAPY* has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to *CREST PHYSICAL THERAPY*, I agree to forward the practice all health insurance and other third-party payments I receive for services rendered to me immediately upon receipt. I will promptly pay *CREST PHYSICAL THERAPY* for all amounts not paid by my insurer(s) and for which I am responsible according to my insurance plan's participation criteria. This includes but is not limited to co-insurance, deductibles, and non-covered items.

_____I hereby authorize *CREST PHYSICAL THERAPY* to release all information necessary, including medical records, to secure payment.

RECIEPT OF FINANCIAL POLICY STATEMENT

_____ I have reviewed and received the Financial Policy Statement.

_____ I understand my responsibility for the payment of my account.

_____ 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.

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CREST PHYSICAL THERAPY

RECIEPT OF NOTICE OF PRIVACY PRACTICES

_____ I have received and reviewed the Notice of Privacy Practices.

REVOKING RIGHTS FOR PATIENT AGREEMENT

_____ I understand that I have the right to revoke this Authorization, if the revocation is in writing, except if *CREST PHYSICAL THERAPY* has taken action in reliance upon this Authorization or, if this Authorization was given as a condition of obtaining insurance coverage, other law provides that the insurance company has the right to contest a claim under the insurance policy. I understand that I may revoke this Authorization by sending a written request to:

Crest Physical Therapy
66 West Gilbert Street
Red Bank, NJ 07701

This consent shall remain in effect until revoked in writing.

By signing this Authorization, I acknowledge that I have read and understand this Authorization.

_____ _____
Signature (Patient) Date Signature (Authorized Representative) Date

_____ _____
Name Printed Relationship of Authorized Representative to Patient

_____ _____
Patient's Telephone # Patient's Date of Birth

OFFICE USE ONLY

Intake Reviewed by: _____ Date: _____

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