Name_____
Date_____

Remedy Physical Therapy & Wellness, Inc.

Conditions of Admission to Remedy Physical Therapy & Wellness, INC.

MEDICAL CONSENT: The patient is under the control for the attending medical service provider. Remedy Physical Therapy & Wellness Inc. assumes no liability for any act or omission in following the instruction(s) of said provider. The undersigned consents to any physical therapy or wellness services rendered under the general and/ or special instruction of provider.

CONSENT TO RELEASE MEDICAL INFORMATION: I consent to allow Remedy Physical Therapy & Wellness, Inc. to furnish any part of my medical record to any person, company, agency, or other authorized party responsible for all or part of my physical therapy care. By giving my consent, I understand the requester may have access to otherwise confidential information contained within my medical record. Remedy Physical Therapy & Wellness, Inc. may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of service provided, and any administrative operations related to treatment or payment. I understand that I have the right to request restrictions, in writing, regarding how my personal health information is used and disclosed for treatment, payment, and administrative operations. I also understand that Remedy Physical Therapy, Inc. will consider requests for restrictions on a case by case basis, but is not required to oblige to such requests.
Initials: _____

EMAIL/TEXT CONSENT:
I, consent to Remedy PT contacting me via email and text message for the purposes of appointment reminders and payment receipts. I acknowledge that appointment reminders via email/text are an additional service and that the responsibility of attending appointments or cancelling them still rests with me.
I understand that I can cancel the email/text message communication at any time. I understand that they are transmitted over a public network onto a personal telephone or email and as such may not be secure. However, Remedy PT will not transmit any information, which would enable

an individual patient to be identified. I agree to inform Remedy PT if my mobile number/email changes, if I wish to cancel this service, or if my phone is no longer in my possession.
The practice does not share mobile phone or email information with any external organization.
Standard text message rates apply.
Initials: _____

SPECIAL CONSENT: I understand my medical record may contain information specific to drug/alcohol abuse and/or addiction, and/or psychiatric conditions, and/or HIV testing and/or HIV positive diagnosis. Such diagnosis and treatment may not be released without my specific consent. I consent to allow such information to be given to any person, company, agency, or other authorized party responsible for all or part of my physical therapy charges. I can withdraw my consent at any time. My consent is valid for this admission/visit only and when the billing process is complete, it lapses.

CONSENT FOR REVIEW OF MEDICAL RECORDS BY FEDERAL/STATE AGENCIES AND OTHER AUTHORIZED AUDITING AND REVIEW AGENCIES: I understand there are federal/state and other agencies who are required to review, and on occasion, copy parts of my physical therapy record for the purposes of assuring an acceptable standard of physical therapy and that charges for my physical therapy services are correct as stated. I consent to review of my medical records for these purposes alone.

PERSONAL ITEMS: Remedy Physical Therapy & Wellness, Inc. will not be liable for loss or damage to any personal valuables.

FINANCIAL AGREEMENTS: The undersigned agrees, whether he/she signs as agent or patient, that in consideration of the services to be rendered to the patient, he/she hereby obligates himself/herself to pay the amount in accordance with the rates and terms of the business. Should the account be referred to an attorney or collections agency for collection and/or suit, the undersigned shall pay reasonable attorney's fees and collection expenses.
I understand I am financially responsible to Remedy Physical Therapy & Wellness, Inc
Initials: _____

Remedy Physical Therapy & Wellness, Inc.
Therapy, Inc. for charges not covered by this assignment. A photocopy of this authorization shall be considered as effective and valid as the original.
Initials _____

PATIENT CERTIFICATION/AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify the information given by me in applying for payment under

Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information to release sufficient information regarding my diagnosis or treatment for billing purposes. I request payment of authorized benefits be made on my behalf. I assign the benefits payable for physical therapy services to the organization furnishing the services. I understand I am financially responsible to Remedy Physical Therapy & Wellness, Inc. for charges not covered by this agreement.
Initials _____

I have reviewed a copy of the Remedy Physical Therapy & Wellness, Inc. Notice of Privacy Practices, which describes how my health information may be used and shared and how I may obtain access to my health information. I understand that Remedy Physical Therapy & Wellness, Inc. has the right to change this Notice at any time.

I may obtain a current copy of the Notice by contacting Remedy Physical Therapy & Wellness, Inc. at (949) 793-3913.

By signing below, I acknowledge that I have been provided a copy of the *Notice of Privacy Practices*.
Initials _____

By signing below, I acknowledge that I have been offered a copy of the *Notice of Privacy Practices* and I declined it. Initials _____

By signing below, I acknowledge that Remedy Physical Therapy & Wellness, Inc. needs 24 hour notice for appointment cancellation in order to fill the appointment. **No shows will incur a $25 charge**.
Initials _____

IF THE PATIENT IS A MINOR OR LEGALLY INCOMPETENT TO SIGN FOR HIS/HER OWN MEDICAL CARE, THE PARENT OR LEGAL GUARDIAN MAY SIGN IN HIS/HER PLACE FOR ANY OF THE ABOVE CONSENTS.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING AND IS THE PATIENT, OR DULY AUTHORIZED BY THE PATIENT AS THE PATIENT'S AGENT, TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

Patient Name: _____

Patient Signature: _____ Date:_____/_____/_____