

Patient Information/Consent Form

Consent to Physical Therapy Evaluation and Treatment:

I hereby consent to the evaluation and treatment of my condition by a licensed Physical Therapist employed by Atta Rehab, LLC. The Physical Therapist will explain the purpose of tests and procedures over the course of treatment sessions. Response to interventions vary between individuals; hence, outcomes to treatment cannot be guaranteed. The Physical Therapist will communicate potential risks and benefits involved in your treatment and plan of care for optimal outcomes.

Assignment of Benefits and Insurance Proceeds:

I hereby authorize payment of medical benefits to Atta Rehab, LLC. for services rendered. Atta Rehab, LLC. will make reasonable effort to collect insurance proceeds by completing and submitting appropriate forms to the insurance company. I understand that I am personally responsible for the amounts due to Atta Rehab, LLC. for their services including partial or copayments due or full payment in the event insurance does not submit payment for services rendered.

Patient Information Consent Form (HIPPA):

I have read and fully understand that Atta Rehab, LLC. may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating quality of service, and any administrative operations related to treatment or payment. I understand that I have the right to request restrictions regarding how my personal health information is used and disclosed for treatment, payment, and/or administrative services. I understand that I retain the right to revoke consent with written request by notifying Atta Rehab, LLC. at any time, at which point Atta Rehab, LLC. will have 30 days to respond to such request.

Release of Information:

I hereby authorize the release of information necessary to file claims with my insurance company.

Designated Individuals Authorization:

I, _____, hereby authorize the designated parties below to request and receive the release of any protected health information regarding my treatment, payment, or administrative operations related to treatment and payment.

Type of information authorized to be released: Billing & Payments Treatment & Diagnosis

Name: _____ Relationship: _____ Address: _____

Name: _____ Relationship: _____ Address: _____

_____ I do not allow release of medical information to anyone other than myself

Late Cancellation/No Show Policy:

In order to provide quality care to all of our patients, please call our office if you are unable to attend your scheduled appointment. Failure to call at least 24 hours prior to your appointment time or a missed scheduled appointment time will result in a \$40 fee.

I have read and understand the above consents, assignment of benefits, release of information, designated individual's authorization, and late cancel/no show policy above.

Patient/Guardian Signature _____

Date: _____