Patient Notification, Acknowledgement and Consent

Patient's Name:_____ **DOB:**_____

In order to ensure that patients receive time-sensitive information and other informational healthcare messages, we, as the provider of rehabilitation therapy ("Provider", "we," or "our") send notifications to patients that opt-in to receive such notifications. If you (patient is referred to herein as "you," "I," "me," "my," "yourself," and "your") choose to sign this consent and opt-in to receive such notifications from Provider, Provider will not impose a separate charge for these notifications; however, depending on the terms and conditions of your wireless carrier contract and/or plan, fees and/or restrictions may be imposed upon you for receiving notifications from Provider. Please contact your wireless carrier about such fees and/or restrictions prior to providing your consent herein to such notifications from Provider.

It is important to note that certain communications, including, without limitation email and text message, which may contain your protected health information ("PHI"), are not invariably secure since certain communications can be intercepted, delivered and/or addressed to an unintended recipient, and/or improperly accessed while in storage and/or during transmission.

In compliance with the Health Insurance Portability and Accountability Act ("HIPAA"), we are required by law to maintain the privacy and security of your PHI. In addition, pursuant to the HIPAA Privacy Rule and Provider's Notice of Privacy Practices, we will not use and/or disclose your PHI without your explicit written authorization, except as permitted by law for the purposes of payment, treatment and health care operations. Furthermore, when we are authorized and/or permitted to use and/or disclose your PHI, we will limit the use and/or disclosure of your PHI to the minimum amount necessary to accomplish the intended purpose of the use and/or disclosure of your PHI. If you choose to have Provider disclose your PHI to an individual or entity other than yourself, you must properly complete Provider's HIPAA Authorization Form, which is available at the front desk upon request.

You have the right to revoke this consent by providing written notice of revocation to the Compliance Officer. The revocation will become effective on the day the Compliance Officer receives the revocation of the consent, and any prior notification from the Provider will not be subject to such revocation of the consent.

I, the undersigned, hereby consent to receive notifications from the Provider, which notifications may include my PHI, by the following methods of communication that I indicated below, with a full understanding of the risks involved with such notifications from the Provider, and I agree to assume all responsibility for informing the Provider in writing of any changes to any of the methods of communications that I indicated below and for ensuring that the methods of communication that I indicated below are secure, with password protection used where applicable, and I further agree that the Provider shall not be held liable for any unauthorized disclosures of my PHI to a third party through any of the methods of communication I authorized below or for any fees and/or restrictions that may be imposed upon me for receiving notifications from Provider:

☐ Mobile Device***:** (_____)_____Wireless Carrier:_____

☐ Text Message***:** (_____)_____

☐ E-Mail**:** _____

☐ Opt-out of receiving text message and email communications from Provider

*****wireless carrier's standard message rates, data rates, and/or restrictions may apply, and by consenting to receive notifications from Provider you agree to be solely responsible for all fees that you incur from receiving notifications from Provider.

Patient/Legal Guardian Signature: _____ **Date:** _____

PATIENT FINANCIAL RESPONSIBILITY: All bills for your outpatient rehabilitation therapy services will be submitted directly to your insurance carrier. By signature below, you authorize payment of medical benefits directly to this company and understand you are responsible for payments of all services rendered in the event any third party does not pay. If you belong to an HMO/ Managed Care Organization that we participate with, you agree to be responsible for securing necessary referrals and making direct payments as required by your plan. As a courtesy, the company will submit to insurance for therapy service authorizations.
Agree: _____ (patient signature)

CO-PAYMENTS, DEDUCTIBLES and FEES: The company is legally and contractually required to comply with the payment policies set forth by each insurance plan. As a result, the company will not uniformly waive co-payments and/or deductibles. Copayments must be paid in full before each treatment session. If you choose to issue your co-payments on a weekly basis, payment is due prior to your first treatment session of the week. If you wish to cancel or reschedule an appointment, we require a minimum of 24-hour advance notice. Less than 24-hour notice may result in a $50 cancellation fee.
If you have frequent cancellations or fail to keep two appointments without notice, you may be discharged from the program. Applicable cancellation fees may be charged to your patient account. If you are experiencing financial hardship, you may qualify for financial assistance with the cost of your services. Please ask to speak to a member of the company to discuss. In the event it becomes necessary to refer your account for collection, you will be held responsible for the attorney fees and collection costs.
Agree: _____ (patient signature)

CONSENT FOR TREATMENT AND CARE FOR ADULT PATIENT: By signature below, you agree and give consent to receive outpatient rehabilitation therapy services by the company and as such consent to receive rehabilitative treatment as considered necessary and proper by the treating therapist(s) in treating my physical condition. No guarantees have been made regarding the projected outcome of care. I understand I have the opportunity and am encouraged to ask questions about my care and treatment.
Agree: _____ (patient signature)

CONSENT FOR TREATMENT OF MINOR: By signature below, I agree and give consent as either parent or legal guardian for my minor child who is under the age of 18 ("Minor") to receive outpatient rehabilitation therapy services by the company and as such grant
consent for Minor to receive rehabilitative treatment as considered necessary and proper by the treating therapist(s) in treating Minor's physical condition. No guarantees have been made regarding the projected outcome of care. I understand that as parent or legal guardian I have the opportunity and am encouraged to ask questions about Minor's care and treatment. I further understand that as parent or legal guardian of Minor, I must accompany Minor to his/her Initial Evaluation. I further understand that as parent or legal guardian of a Minor under the age of 12, I must be present during all care or treatment rendered to Minor. As parent or legal guardian, I am not required to attend follow up treatment sessions if Minor is 12 years or older.
Agree: _____ (parent or legal guardian signature)

MOTOR VEHICLE/NO FAULT/WORKERS' COMPENSATION: If I have been involved in a motor vehicle accident or a workers compensation injury, I agree it is my obligation to disclose that to the company. I understand and agree that I must complete and submit No Fault application to my carrier within 30 days of accident date (or other period as determined by my carrier or applicable law) and comply with any Independent Medical Examination (IME) requests. If I fail to do so, I understand and agree that I will be held responsible for all payments until the time of settlement, judgment, or payment by attorney or the automobile insurance company. If I sustained an injury on the job and are receiving Physical, Occupational and/or Speech Therapy under Worker's Compensation I understand and agree that I will comply with all requests set forth by Worker's Compensation laws and carriers.
Agree: _____ (parent or legal guardian signature)

I have read this Patient Notification, Acknowledgement and Consent. I have received a copy of the HIPAA Notice of Privacy Practices. I hereby agree to receive treatment and physical, occupational and/or speech therapy services in accordance with the above stated terms.

Patient Signature: _____

Printed Name: _____

Date:_____