Outreach Physical & Occupational Therapy
& Speech Rehabilitation, PLLC
1110 2nd Avenue Suite 302, NY, NY 10022, ph. # 212-842-0080, fax# 917-591-8494

Authorization and acknowledgments

Dear Valued Patient:

Consent for Care:

I, the undersigned, do hereby agree and give my consent for Outreach Physical and Occupational Therapy & Speech Rehabilitation, PLLC., to furnish medical care and treatment considered necessary and proper in diagnosing or treating his/her physical and medical condition.

Physical, Occupational or Speech Therapy involves the use of many different types of evaluation and treatment procedures. We use a variety of treatment procedures to help us try and improve your overall function. As with all forms of medical treatment, there are benefits and there are risks involved. We are not able to guarantee precisely what your reaction to a particular treatment might be, nor can we guarantee that our treatment will help the condition you are here seeking treatment for. There is also a risk that your treatment may cause pain or injury or may aggravate previous existing conditions. You have the right and should ask your Therapist what type of treatment he or she is planning based on your history, diagnosis, symptoms and testing results. You have the right to decline any portion of your treatment at any time before or during your treatment session. I recognize that there are no guarantees that can be made regarding the likelihood of success or outcome of any therapy rendered at Outreach Physical and Occupational Therapy and Speech Rehabilitation, PLLC

Patient or guardian signature x _____ Date_____

RELEASE OF INFORMATION

I authorize the release of information requested by my insurance plan for payment.

I understand that I am responsible for any balance due

Patient or guardian signature x _____ Date _____

HIPAA: Health insurance Portability and Accountability Act

With my permission, Outreach Physical and Occupational Therapy and Speech Rehabilitation, PLLC may use and disclose protected health information (PHI) about me to

carry out treatment, payment and healthcare operations (HCO). With my permission, Outreach Physical and Occupational Therapy and Speech Rehabilitation, PLLC may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (HCO).

With my permission, the offices of Outreach Physical and Occupational Therapy and Speech Rehabilitation, PLLC may call my home or other designated locations and leave a message on voicemail, or in person, in reference to any items that assist in the practice in carrying out HCO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including Evaluations, tx. notes, DC summaries pertaining to HCO among others.

Patient or guardian signature x_____ Date_____

Appointment Cancellation Policy

We urge you to keep every appointment, as consistent treatment will speed up your recovery process. Please be advised, that if for any reason, you must cancel your appointment with us, it is our "Company Policy," that **Outreach Physical & Occupational Therapy & Speech Rehabilitation, PLLC,** receives notification in 24 hours of your scheduled visit. Arrival more than 15 minutes after your scheduled appointment may be considered a failed appointment.

Further, and in keeping with our "Company Policy," if this prior notification is not received a "Cancellation Fee" in the amount of $50 (fifty dollars) per cancelled appointment will be charged to your account.

Patient or guardian signature x_____ Date_____

Financial/insurance responsibility for all patients:

I understand and agree to the following policies regarding financial and insurance responsibilities. Payment is required at or before each visit. I am responsible for charges incurred for all treatment rendered. This responsibility includes co-pay, co-insurance, deductible amounts, non-covered and excluded items not paid for by my insurance carrier or other party responsible for coverage of medical expenses. I agree that I am responsible for any payment of services my insurance carrier determines, either now or a later date, to be unreasonable or not medically necessary. I also agree to be responsible for costs and expenses, including court costs, attorney fees and interest, should it be necessary for Outreach PT, OT and ST, PLLC to take action to secure payment of an outstanding balance owed.

Treatment authorization:

I authorize Therapy treatment of myself or whom I have legal guardianship over by the Therapist and staff at Outreach Physical and Occupational Therapy and Speech Rehabilitation, PLLC.

Patient or guardian signature x_____ Date_____

I certify that the information I provided to my doctors, therapists and insurance company is correct. I consent to Therapy treatments offered or recommended to me by my Doctor or Therapist. I intend this consent to apply to all my present and future Therapy care.

Patient name x_____ Date_____

Patient or guardian signature x _____ Date_____