Outreach Physical & Occupational Therapy & Speech Rehabilitation, PLLC

Personalized In-Home Treatment
1110 2nd Ave., Suite 302, NY, NY 10022, ph. # 212-842-0080, fax# 917-591-8494

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.

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 _____

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_____

Appointment Cancellation Policy

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 by 9am the morning of your scheduled visit.

Further, and in keeping with our "Company Policy," if this prior notification is not received and your Therapist is in transit or arrives at your home, 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_____

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_____

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 or guardian signature x_____ Date_____

Print name_____ Date_____