## *ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**1. Patient consent to Treat**

I, the undersigned patient, consent to such treatment procedures as are deemed necessary by the providers including those which are in addition to or different from those initially contemplated, and which are deemed necessary or advisable by the provider in the course of treatment.

2. **Patient Consent for Use and Disclosures of Protected Health Information ("PHI")**

I, the undersigned patient, give my consent to the provider entity and it's agents to use or disclose my protected health information ("PHI") to carry out treatment payment, or health care operations. These individuals and entities can release, use or disclose my PHI to other healthcare personal including, but not limited to, physicians, certified registered nurse anesthetists, anesthesia assistants, nursing staff, nurse practitioners, physicians assistants, child life specialists, physical therapists, respiratory therapists, X-ray personnel, audiologists, and healthcare operations, as determined in the sole discretion of the provider, his/her practice group and their respective agents.

3. **Permission to Release Medical Records to Providers**

If another provider who is involved with my treatment, payment or healthcare operations relating to me, requests my medical records, I consent to the release of my entire medical record maintained by the provider to those other providers.

4. **Permission to Release Billing Information Over the Telephone**

I, agree as part of this consent for payment operations, that the provider, it's group, and their billing personnel, billing agents, or management company can disclose billing information to any person who calls the provider with billing questions after the provider inquires as to identity of the calling person and the calling person provides my correct social security number or health plan number.

5. **Permission to Call and leave a Voice Message**

I agree that the provider or it's agents or representatives may call and leave a voice message at my house or other number I provide the regarding medical appointments, billing or payment issues, or other information related to treatment, payment or health care operations.

6. **Permission to Discuss Protected Health Information with Third Persons**.

I agree that the provider may discuss my PHI with any persons who accompanies me to a visit or procedure or is present with me when the provider is present. The provider may rightly assume that if another person is with me, I have no objections to disclosure of PHI to that person. I also agree that the provider may discuss my PHI with any person who identifies him or himself as active in my mental, physical, emotional, or spiritual care, including but not limited to family, friends, clergy and patient advocates, I also agree that the provider, his/her practice group, and their agents may disclose my PHI to employers who arrange and pay, directly or indirectly, for my medical treatment.

7. **Permission to Discuss Protected Health Information Regarding Minors**.

I agree that the provider, his/her practice group, and their agents may, upon request by the following entities disclose my PHI to public health agencies, law enforcement, and the FDA.

8. **Permission to Discuss Protected Health Information with Public Agencies**

I agree that the provider, his/her practice group, and their agents may, upon request by the following entities disclose my PHI to public health agencies, law enforcement, and FDA.

9. **Acknowledgment of Receipt of Notice of Privacy Practices**

I acknowledge that I have the option to receive this provider's copy of a separate document, entitled "Notice of Privacy Practices" which sets forth this providers privacy practices and my rights regarding privacy of my PHI.

_____ _____

SIGN Patient Name Date

_____

PRINT Patient Name

Duanesburg Physical Therapy
4780 Duanesburg Road
Duanesburg, NY 12056

# Duanesburg Physical Therapy Associates

## Cancellation Policy

The staff at *Duanesburg Physical Therapy, schedules* individual appointments to treat you. We make every effort to see you in a timely fashion and offer you the highest quality treatment. We ask that you keep your scheduled appointment. We understand that occasionally events occur that prevent you from attending therapy. We ask that you cancel with our office at least 24 hours in advance. If you do not keep your scheduled appointment, and fail to cancel the appointment, you may be charged a fee of $25.00.

**Please be advised that some treatments are contraindicated with certain conditions. It is important that you advise your therapist of any prior medical conditions you may have, i.e. cardiac, prior surgery, immune disorders, etc. All information will be kept confidential. Thank you.**

**INITIAL: _____**

## Financial Policy Insurance Authorization/Responsibility Agreement below

Our office is committed to providing you with the best possible care. We must emphasize that as medical providers, our relationship is with you, not your insurance company. While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date service is rendered. We realize temporary financial problems may effect timely payments of your account balance due. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

*I authorize my insurance company to pay the proceeds of any benefits due directly to *Duanesburg Physical Therapy.*

*I agree to pay my co-payments (if any) as services are rendered. If for any reason a balance is owed on my account, I agree to pay that promptly upon receipt of statement.

*I authorize *Duanesburg Physical Therapy* to release such information as required by my attorney and/or insurance company to secure my insurance benefits. I understand I will be responsible for services not covered by my insurance company and failure to supply necessary referrals, or prescription to secure payment of my account. A photographic copy of the authorization shall be valid as the original.

**INITIAL: _____**

## Permission to Treat

I hereby agree and give my consent to medical treatment in treating my physical conditions. I authorize release of any medical information needed to process my claim. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes that occur. I authorize release of payment directly to Duanesburg PT regardless of participation in or out of network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs that are incurred.

Patient/Parent/Guardian, Signature: _____ Date: _____

Witness: _____Date: _____