Optimum Wellness
Physical Therapy

CONSENT FORM/RELEASE OF INFORMATION

Patient Name _____

CONSENT TO EVALUATION AND TREATMENT
I hereby consent to evaluation and treatment by Optimum Wellness Physical Therapy and authorize Optimum Wellness Physical Therapy to render health care services to me. I understand that all Optimum Wellness employees and representatives will be adequately experienced and supervised. I further understand that it is my right to accept or refuse any treatment offered to me. I understand that my proposed plan of care is initially provided according to my physician's orders, and is subject to change as my condition changes and/or as specifically ordered by my physician. I expressly acknowledge and understand that no guarantee has been made to me as to the results that may be obtained from such treatment.

RELEASE OF INFORMATION
I authorize Optimum Wellness Physical Therapy to release information from my medical record, whether it be written, video, photographic, audio or verbal, to my physician and/or any third party payer (such as an insurance company or governmental agency) for (i) the processing of claims for payment; and (ii) communication and care coordination on my behalf. I understand the nature of this authorization and have been informed that I have the right to revoke consent at any time by written communication to Optimum Wellness Physical Therapy. I consent to the use of non-personally identifying information from my medical record for the purpose of outcome analysis. I acknowledge that the contents of the information disclosed by Optimum Wellness Physical Therapy may include HIV/AIDS related diagnosis, drug and alcohol and psychiatric diagnosis.

PRIVACY PRACTICES
I acknowledge receipt of the Optimum Wellness Notice of Privacy Practices, which I have received at the time of this appointment or previously.

ASSIGNMENT OF BENEFITS
I request that payment of the Medicare/Other Insurance benefits be made on my behalf to Optimum Wellness Physical Therapy for any services furnished to me by Optimum Wellness Physical Therapy. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

FINANCIAL AGREEMENT
The undersigned agrees, whether signing as an agent or patient, that s/he individually obligates her/himself to pay for services rendered in accordance with the regular rates and terms of Optimum Wellness Physical Therapy. Optimum Wellness Physical Therapy will verify insurance benefits on behalf of the patient. Verification is no guarantee of payment. The agent/patient is responsible for any co-payment, deductible, coinsurance and all amounts identified by the insurer as the patient's responsibility.

Medicare Patients: I understand that if I do not have supplemental insurances, I will be responsible for the twenty percent (20%) co-insurance portion not paid by Medicare as well as any deductible.

The undersigned certifies the s/he has read, understood and accepts the terms of this form, received a copy, and is the patient or is duly authorized by the patient as the patient's general agent to execute this form.

_____ _____
Signature of Patient or Responsible Party Date

_____ _____
Witness Date