Cedar Valley Physical Therapy, PLLC

PATIENT INFORMATION CONSENT FORM

I have read and fully understand Cedar Valley Physical Therapy's Notice of Patient Information Practices. I understand that Cedar Valley Physical Therapy may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluation of the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify Cedar Valley Physical Therapy in writing. I also understand that Cedar Valley Physical Therapy will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

Cedar Valley Physical Therapy has my permission to photograph, film, videotape or otherwise make video/audio recordings of me solely for the purposes of diagnosing and treating my condition. No photograph or videotape will be used for any other purpose other than treatment without my written consent.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Cedar Valley Physical Therapy's Notice of Patient Information Practices. I understand that I retain the right to revoke this consent by notifying Cedar Valley Physical Therapy in writing at any time.

ASSIGNMENT OF BENEFITS

I hereby assign all medical benefits to which I am entitled to Cedar Valley Physical Therapy in the event they file insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of this debt. This includes but is not limited to collection service fees, attorney's fees, and all court costs and additional legal fees associated with the recovery of this debt. By providing us with your wireless/cell phone number, you are hereby granting us and our agents or independent contractors, your consent to receive calls on your wireless/cell phone number for billing and debt collection purposes. Interest may be charged at a rate of 1.5% per month (18% annually for unpaid balances over thirty days old. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of Cedar Valley Physical Therapy as may be dictated by prudent medical practice by my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

_____

Patient Name

_____

Signature of Patient or Legal Guardian

_____/_____/_____

Date