Patient Name: Date of Birth: Evaluation date:

CENTRAL OHIO PHYSICAL THERAPY

REGENERATE • RESTORE • REHAB

Patient Name:_____Patient Phone_____.

Address:_____City: _____State:_____Zip:_____.

Patient Rights & Responsibilities

I acknowledge the receipt of information pertaining to my right to accept or decline the disclosure of my personal health information that is protected by HIPPA policy to Central Ohio Physical Therapy. In granting my permission, I will allow my personal health information to be shared with Central Ohio Physical Therapy, to screen for any physical or environmental needs that may or may not be present.

Consent for Treatment

I hereby give my permission for authorized personnel of Central Ohio Physical Therapy to perform all necessary procedures to assess for any needs delivered via physical therapy care. If applicable, I understand my physician will be contacted and services will be rendered through Central Ohio Physical Therapy. I understand that Central Ohio Physical Therapy will supervise services provided, I may refuse treatment or terminate services at any time, and Central Ohio Physical Therapy may terminate their services to me as explained in my orientation. I agree and consent to allow my personal health information to be shared with COPT. In doing so, I consent to allow a professional from Central Ohio Physical Therapy including but not limited to physical therapy assess my needs.

Release of information

I acknowledge receipt of the Notice of Privacy Practices and was given an opportunity to ask questions and voice concerns. I understand that Central Ohio Physical Therapy may use or disclose protected health information from insurance companies, health plans, Medicare, Medicaid, or any other person or entity that may be responsible for paying or processing for payment any portion of my bill for services, any person or entity affiliated with or representing for purposes of administration, billing, and quality and risk management; any hospital, nursing home, or other health care facility to which I may be/have been admitted; any assisted living or personal care facility of which I am a resident; any physician providing my care: family members and other caregivers who are part of my plan of care; licensing and accrediting bodies, and other health care providers in order to initiate treatment.

Consent to Photograph

I hereby consent for Central Ohio Physical Therapy to take pictures of myself and treatment being done and consent to the release of those photographs for use in advertisement or public education regarding physical therapy services or to insurance providers to document my medical condition.

Advance Directives

I understand that the Federal Patient Self-Determination Act of 1990 requires that I be made aware of my right to make healthcare decisions for myself. I understand that I may express my wishes in a document called an Advance Directive (Living Will/Durable Power of Attorney for Health Care) so that my wishes may be known when I am unable to speak for myself.

1.I have made a Living Will ____No____Yes (if yes, provide a copy to the agency.)

2.I have made a Durable Power of Attorney for Medical Care ____No____Yes (If yes, write the name & phone number of the person given power of attorney.

I authorize Central Ohio Physical Therapy to use and disclose the protected health information described above to the following individuals:

Name: _____Relationship: _____

Name: _____Relationship: _____

Name: _____Relationship: _____

I understand a copy of this consent form shall be as valid as the original and shall remain in effect until I am discharged from Central Ohio Physical Therapy care. I also understand that I may revoke this consent in writing at any time.

_____ _____

Patient's Signature

Responsible person or legal guardian's signature/person Authorized to sign

_____ _____

Witness Signature/Agency Representative

Printed Name & Relationship of Person Above

Patient unable to sign due to_____