CAROLINA BEACH CBPT PHYSICAL THERAPY

CONSENT TO THERAPY

I hereby consent to the evaluation and treatment of my condition by a licensed physical therapist and support staff employed by Carolina Beach Physical Therapy, LLC. (CBPT). I understand that the physical therapist will explain the purpose and procedures they will perform. I will also be informed as to the expected benefits or potential complications as a result of participation.

Initial _____

1) I realize I have the right to refuse any treatment or procedures to the extent permitted by law. I understand the delivery of healthcare is not an exact science, so no guarantees or warranties can be made to me regarding the result of any treatments at this facility. I understand the information from medical records kept by this facility may be used for educational, administrative and/or facility approved purposes and my personal identity will not be revealed.

   Initial _____

2) I authorize payment of medical benefits to Carolina Beach Physical Therapy, LLC. for services rendered. I understand that CBPT will make reasonable effort to collect insurance proceeds by submitting billing information for processing. Completion of such forms and/or the acceptance of assignment of insurance benefits does not relieve the undersigned of the obligation to pay the amount owed for physical therapy.

   Initial _____

3) I understand that copayments/co-insurances are due at the time of service. I understand that CBPT does have a payment plan if you need to extend your payments over a longer period of time.

   Initial _____

4) I understand that CBPT has a **STRICT FRAGRANCE POLICY.** Please refrain from wearing perfume, cologne, or lotion to therapy sessions. We have patients and staff who suffer from asthma and respiratory problems and are highly sensitive to strong odors and fragrances.

   Initial _____

5) I authorize the release of medical information necessary to process my insurance and authorize payment directly to the provider of service. I am responsible for any services not covered by this authorization. I have read and fully understand the Patient Financial Responsibilities Form.

   Initial _____

6) Worker's Compensation-I hereby authorize my case manager to receive my records related to my work injury.

   Initial _____

7) I understand that my doctor will automatically receive a copy of my records at no charge; and that if I or anyone else indicated above request and obtain a copy of my medical records, I will be responsible for a 25¢ fee per page of records provided

   Initial _____

Acknowledgment of the "Notice of Privacy Practices" release of medical information request.

I have been given the opportunity to review Carolina Beach Physical Therapy's "Notice of Privacy Practices". This document contains a description of the uses and disclosures of my protected healthcare information and my rights regarding such information. CBPT displays the "Notice of Privacy Practices" in its clinic reception area. I understand that CBPT has the right to change its "Notice of Privacy Practices" and that if changes are made, a revised copy of the notice will be posted in the reception area. I also understand that I have if I have any questions or wish to receive copies of the current "Notice of Privacy Practices", I may request that document from the front desk or access it from the CBPT website. I permit a copy of this form to be used in lieu of the original.

Initial _____

I authorize CBPT, LLC (CBPT) to obtain a release health information from/to the following:

_____
Name of person or Name of facility

_____
Name of person or Name of facility

_____
Name of person or Name of facility

If you are the representative for the patient, check the scope of your authority to act on the patient's behalf:

❑ Power of Attorney ❑ Guardian ❑ Parent ❑ Other

I have read and fully understand the above general consent form. Any questions I have have also been answered to my satisfaction. By signing this form I am acknowledging my understanding of the "notice of privacy practices" and authorizing persons or institutions listed on the information release to receive or not receive my health information.

_____ _____
Signature of Patient or Parent Date