285A Pascack Road
Washington Township, NJ 07676
201-358-9200 (P) 201-358-9201 (F)

CONSENT AND AUTHORIZATION

Consent to Treatment: I hereby consent to physical therapy and related services at Foundations Physical Therapy. I understand and acknowledge that such physical therapy and related services may involve direct bodily contact.

_____

(initial)

Authorization of Payment: I hereby assign all benefits directly to Foundations Physical Therapy and authorize the release of any medical records necessary to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices.

_____

(initial)

HIPAA Notice of Privacy Practices: I have read and understand the Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices.

_____

(initial)

Communications: I hereby grant Foundations Physical Therapy the permission to leave a message regarding my current health status and treatment program on my answering machine/ voicemail.

_____

(initial)

I hereby grant Foundations Physical Therapy permission to discuss my medical condition with:

Name: _____

Relationship to Patient: _____

Patient Name (please print): _____ Date: _____

Patient Signature:

_____

Guardian Name (if patient is under 18 years old):

_____

Guardian Signature:

_____