1425 Ala Kopiko St
Honolulu, HI 96818
Phone: (808) 599-0215
Fax: (866) 311-6249

Physical Therapy Consent Form

PATIENT'S NAME: ___________________________________

1. **CONSENT:** I consent to physical therapy services provided by **On The Move Therapy LLC**. I know if I have any questions about my care, I should be sure to ask the physical therapist about them. I know it is up to me to inform the physical therapist/staff about any health problems or allergies I have. I must also tell the physical therapist/staff about drugs or medications I am taking.

2. **RELEASE OF INFORMATION: On The Move Therapy LLC** releases patient health care information for purposes of treatment or payment, or to other health care organizations, as explained in our HIPAA Notice of Privacy Practice. I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.

3. **INSURANCE:** I authorize the staff at **On The Move Therapy LLC** or contracted billing services to review my insurance coverage with my insurance company. I understand that my insurance benefits are only a quote of benefits and not a guarantee of payment. I understand that what I am quoted by **On The Move Therapy LLC** and/or my insurance company may differ from what I may owe at the conclusion of physical therapy. I understand it is my responsibility as the patient to know my insurance coverage. I authorize payment of my insurance benefits to be made directly to **On The Move Therapy LLC.** I agree to pay in full any and all charges not covered by insurance or other benefits. I understand that it is unlawful for **On The Move Therapy LLC** to waive co-pays, co-insurances, and deductibles that are my responsibility. For any returned check, there will be a $25.00 fee added to my responsibility that will be included in your bill. If I do not pay my bill in the specified timeframe, then my balance will be sent to a collection agency and any collection fees will be added to the unpaid balance and will be my responsibility.

4. **NOTICE OF PRIVACY PRACTICE:** I have read the **On The Move Therapy LLC** Statement of Privacy Notice located on the back of this form and I understand that a copy of the notice will be provided to me upon my request.

5. **CANCEL/NO SHOW/LATE POLICY:** If you must cancel your scheduled appointment, a 24-hour notice is required. **Cancels with a less than 24-hour notice will result in a $25.00 fee applied to your account.**

I certify that any and all information provided by me in furtherance of my application for health care benefits are true. I have read the front and the information on the back of this form. It has been fully explained to me and all of my questions about the form have been answered. I understand its contents.

_____________________________ _________________________________

Patient Signature **Date**

On The Move Therapy LLC
Statement of Privacy Notice

Effective September 2011

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

We may disclose your health information in the course of any administrative or judicial proceeding.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

We may disclose your health information to coroners or medical examiners.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

We may leave a message on an automated answering device or person answering the phone for the purposes of scheduling appointments. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

We may contact you by phone, mail, or email. "It is our practice to participate in charitable and marketing events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity.

In the event that we are sold or merged with another organization, your health information/record will become the property of the new owner.

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.

- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

- You have the right to inspect and copy your health information.

- You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

- You have a right to receive an accounting of disclosures of your protected health information made by us.

- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact us by calling the office.

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide On The Move Therapy LLC with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.