INSURANCE INFORMATION AND CONSENT

I hereby authorize **Amity Physical Therapy LLC** to furnish information concerning my illness and treatments to insurance carriers and any other payor to process and collect this claim. I hereby assign to **Amity Physical Therapy LLC** all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. I also agree to receive treatment at **Amity Physical Therapy LLC** today.

CONSENT
In order to improve my physical condition in regards to pain, range of motion, strength, or another type of physical impairment, I consent to enter the Amity Physical Therapy program for evaluation and treatment. Treatment may include but not limited to: modalities, manual therapy, joint mobilization, trigger point dry needling, supervised exercises, balance training, and home exercise prescription.

RISKS
I am aware that there are certain risks involved with a physical therapy program. Every effort is made to minimize my risk by continuous assessments of my condition throughout my therapy. The clinician will explain the pros and cons to all the treatment techniques, including: expected results, timeframes, and potential complications/side effects. Please direct any and all questions at the time services are being administered

RESONSIBILITIES
- I will inform my therapist **of any** changes in my medical condition, or medications, as they may necessitate change in my therapy program.
- I will stop any procedure or activity and inform my therapist of any symptoms of pain, fatigue, shortness of breath, dizziness or nausea that may develop during my treatment.
- As a courtesy, Amity Physical Therapy will verify your insurance coverage for you. We will notify you of your co-payment, co-insurance or deductible amount. This is not a guarantee of payment by your insurance company and any discrepancy in coverage is between you and your insurance company.

I authorize the release of any medical or other information necessary to process this claim. I also request payment of governmental benefits either to myself or to the party who accepts assignment below.

I authorize payment of medical benefits to the undersigned physician or supplier for services received.

SIGNATURE _____ **DATE** _____

HIPAA PRIVACY NOTICE

I have reviewed the Notice of Use and Disclosure of Protected Information. I understand this notice and have had the opportunity to ask any questions regarding matters of concern.

I have read, understand and agree to the above listed categories

SIGNATURE _____ **DATE** _____
This notice was effective beginning October 1, 2013