EXERCISABILITIES
PHYSICAL THERAPY & MEDICAL FITNESS

Authorization and Consent

Name: _____
Date: _____

Authorization for Treatment: I consent to the rendering of treatment from Exercisabilities, Inc. Treatment may include physical therapy, occupational therapy, speech therapy, dietitian services, recreational services, or fitness services. I understand this Authorization and Consent to Treatment and understand that no guarantee or assurance has been made as to the results that may be obtained.

Potential Benefits: You may experience improvement in your symptoms and functional activities as well as resolution of other key complaints or problems. In addition to treatment, we provide education to you about your condition throughout your episode of care. This education is often accompanied by handout material that you can refer to regarding proper techniques and home program execution. These resources will help you maintain a sound level of function and will also help you minimize symptoms, should they reoccur.

Potential Risks: You may experience an increase in your current level of pain, if pain is part of your complaints. Many times increased activity or therapy interventions will bring on some discomfort, this is usually temporary. If your pain or discomfort does not subside within twenty-four (24) hours, you should discontinue any home program involving that particular activity, if applicable, and contact your therapist.

Alternatives: We establish a Plan of Care based on the best interventions for your condition, but on occasion our choice of treatment is not well tolerated. You are asked to voice any unfavorable reaction you experience to any aspect of your treatment so that we can modify or terminate it promptly and progress your rehabilitation. If you decide not to continue your participation in your therapy program you will be asked to consult with your physician about other treatment alternatives.

Privacy policy and Patient Rights: I, the client, acknowledge that I have been presented with the document Notice of Privacy and Non-discrimination Policy, which can be viewed at www.exercisabilities.org. I recognize that outside of purposes for treatment, for payment, for certain healthcare operations or as permitted or required by law I must give my written authorization to Exercisabilities, Inc. to release any of my protected healthcare information.

Use of phone: I agree Exercisabilities, it affiliates or agents, may use an automated telephone dialing system, pre-recorded messages, and texting to contact the wireless number(s) and or residential lines I provide for appointment and payment reminders.

Payment of Services: I agree to pay for all services rendered to me by this facility. I acknowledge that I am responsible for all charges for services provided. I agree that Exercisabilities may obtain financial information to determine eligibility for financial assistance or payment options.

Authorization to assign benefits and release information: I authorize my Payer(s) to pay directly to Exercisabilities, Inc any benefits due under the terms of my health care plan(s), for services provided by Exercisabilities, Inc. I understand that Exercisabilities, Inc reserves the right to refuse or accept assignment of medical benefits. If I am a Medicare Beneficiary, I request payment of authorized Medicare benefits to me or Exercisabilities, Inc on my behalf for any services furnished. If my health plan (s) will not allow direct payment to Exercisabilities, Inc or if Exercisabilities, Inc chooses not to accept assignment of medical benefits, I agree to pay Exercisabilities, Inc all health care payments I receive for services. I authorize Exercisabilities, Inc to contact my Payer(s) to obtain all pertinent financial information concerning coverage and payments made under my health care plan (s) and for my Payer (s) to release such information to Exercisabilities, Inc.

Authorization to Release Medical Information: I authorize Exercisabilities, Inc to release all medical information as necessary to:

- All Payers for processing health care claims.
- The person (s) I designate as my billing addressee/guarantor for handling my billing, payment and health care coverage for my account. (see Request for Confidential Information Form)
- My health care providers for treatment or payment purposes
- Other providers at Exercisabilities for the provision of my treatment.
- I authorize Exercisabilities to share my past, current, and future health, treatment, and account records about services I've received from Exercisabilities and other health care providers as needed to manage or coordinate my care and to improve the quality of that care.
- A health record information exchange allows my health care providers to electronically access my health information held by other participating providers to provide me better care. I authorize Exercisabilities to access any of my health information that is available in an HIE, and Exercisabilities will also make my information available through HIEs in which it participates unless I opt out. If I opt out, by checking the box below, Exercisabilities will exclude all of my health information from the HIEs in which Exercisabilities participates in. ☐ **HIE opt out**
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I have read the above information and I consent to above terms. I understand that I have the right to revoke the authorizations on this form at any time by notifying Exercisabilities in writing.

○ I am over 18 ○ I am 17 Years or younger

Signature: _____ Date: _____

_____ _____

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Name: _____
Date: _____

Printed name of person (if not patient)

Relationship to patient