Consent and Privacy Information Form

1. Consent For Treatment: I hereby consent to, and authorize my physical therapist to provide care and treatment prescribed by my physician and/or considered necessary or advisable by my physician, physical therapist or other healthcare professionals. My consent to treatment is ongoing and I may revoke it verbally at any time during treatment. I understand that it is my responsibility to inform my physical therapist or other health care professional if I experience any discomfort or pain during any treatment or if I have other unresolved concerns around my treatment. I understand that response to physical therapy intervention varies from person to person and it is possible that treatment may result in aggravation of existing symptoms or may cause pain or injury. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

2. Telehealth: Some patients may be eligible for treatments performed via telehealth, videoconferencing. We use the teleconferencing platform Zoom, which is HIPAA compliant with end-to-end secure encryption. Options for telehealth treatment may be discussed with your physical therapist.

3. Access To And Release Of Health Information: I understand that Amber Cross DPT, LLC doing business as Amber Cross Physical Therapy will document medical and other information related to my treatment in electronic forms and that such information will be used in the course of my treatment, for payment purposes and to support those who are caring for me. I authorize my clinician(s) and Amber Cross Physical Therapy administrative staff to contact other healthcare professionals that may have information related to my prior and current health conditions and treatment.

4. I understand communication with Amber Cross Physical Therapy will include secure lines by phone/voicemail and fax. If I choose to text or email with the business or therapist the communication will not be encrypted and thus not considered secure. If I choose to send sensitive personal health information by text or email I accept all risks associated with that action and do not hold Amber Cross Physical Therapy liable.

5. Assignment of Benefits: I, the undersigned or designated representative for the patient, do hereby assign all medical benefits of which I am entitled to Amber Cross Physical Therapy in the event they file insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid by said insurance. I do hereby authorize Amber Cross Physical Therapy to release all information necessary to secure the payment of said benefits.

   I have been given an opportunity to ask questions, and all my questions have been answered to my satisfaction. I confirm that I have read and fully understand this form. In the event of a change in medical status, I understand that my treatment may be modified, stopped, or referred out to the proper practitioner. I reserve the right to withdraw at any time.

_____ Initial if applicable, or leave blank.

I want Amber to share information with someone other than my referring provider, named below.

Name:

Name:

Name:

Printed Name_____ Date_____

Signature_____