HARAGUCHI
PHYSICAL THERAPY & ORTHOPEDICS

PATIENT CONSENT

I consent to any medical treatment rendered under the general and special instructions of the physician and/or physical therapist.

I understand that therapeutic procedures can include, but are not limited to: joint and soft tissue mobilization, home exercise programs, therapeutic exercises, neuromuscular education, gait training, functional training including: posture and body mechanics, modalities, such as heat, ice, electrical stimulation, ultrasound, laser, and special procedures such as: taping, neuromuscular electrical stimulation, mechanical traction, and bladder training, evaluation and treatment of functional loss due to related nerve, muscle, and skeletal dysfunctions and/or pain.

I understand that I may refuse any therapeutic procedure or treatment at any time.

_____ _____ _____

Patient Name (or Responsible Party) Signature Date

PATIENT FINANCIAL RESPONSIBILITY

I hereby assign all physical therapy benefits to Haraguchi Physical Therapy & Orthopedics for services rendered to me or said minor patient. I authorize any holder of medical information about me or said minor to release to my insurance company any information needed to determine these benefits payable for related services. I understand that if my insurance benefits and/or eligibility DO NOT COVER OR APPROVE PAYMENT FOR SERVICES PROVIDED BY HARAGUCHI PHYSICAL THERAPY & ORTHOPEDICS, I AM FINANCIALLY RESPONSIBLE AND AGREE TO PAY FOR ALL CHARGES RELATED TO SERVICES RENDERED. This includes, but is not limited to; services deemed 'non-covered' or 'not medically necessary' by my insurance.

I understand my signature requests that payment be made to Haraguchi Physical Therapy & Orthopedics and authorize release of medical information necessary to pay the claim.

_____ _____ _____

Patient Name (or Responsible Party) Signature Date

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this policy carefully. For more detailed information, please request a printout.

Understand your health record and information:

When receiving physical therapy services from HARAGUCHI PHYSICAL THERAPY & ORTHOPEDICS, LLC. a record is made of your treatment. This record contains your symptoms, diagnoses, examinations, assessments, evaluation, your treatment plan, daily treatment notes and progress notes.

Our pledge regarding medical information:

We understand that your medical information is personal and private. We are committed to protecting your information. Medical records are only disclosed in a limited amount of circumstances which may be regarding; **treatment , payment, review for quality of care, federal, state, or local law, and lawsuits/disputes.** If for any reason, you would like a copy of your entire record, please make your request in writing. For your protection, please have proper ID with you if picking up records in the office.

I have read and understand all information outlined above.

_____ _____ _____

Patient Name (or Responsible Party) Signature Date