ept Rehabilitation

Patient Information Consent

1. I, the undersigned give my consent for treatment. I understand that I am financially responsible for physical therapy charges not covered by my insurance plan or for the total charges if no insurance applies. _____ Initial
2. I hereby authorize the staff of *ept* Rehabilitation, to release my medical records to my physician(s), attorney, insurance company, hospital and/or other health care provider. _____ Initial
3. I hereby authorize any physician, hospital and/or other medical providers to furnish medical records to the staff of *ept* Rehabiliation. _____ Initial
4. I understand EPT Rehabilitation has reserved the right to change its privacy practices that are described in the notice. I also understand a copy of any revised notice will be posted in the office or provided to me upon request. _____ Initial
5. I understand that EPT Rehabilitation does not allow recording devices to be used or photos be taken during my visit(s) at their facilities without prior permission. _____ Initial
6. I hereby give EPT Rehabilitation my permission to communicate with me through email and understand that email is an unsecure method of communication. _____ Initial

_____ _____

Patient Signature Date

_____

If you are not the patient, please specify your relationship to the patient