TOTAL BODY REHAB
ORTHOPEDIC AND HAND THERAPY

3530 S. Val Vista Dr Ste 102 Gilbert AZ 85297-7319 8419 E. Baseline Rd Bldg. B Ste 105 Mesa AZ 85209
PHONE (480) 726-1818 FAX (480) 726-2798

CONSENTS

Patient Name: _____ Date of Birth: _____

CONSENT TO TREATMENT: I consent to rehabilitation and related services at TOTAL BODY REHAB. In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature.

LIABILITY: I know and agree that TOTAL BODY REHAB is not responsible for loss or damage to personal valuables.

WAIVER and RELEASE: I hereby release, discharge, and acquit TOTAL BODY REHAB, it's agents, representatives, affiliates, employees, or assigns, of and from any liability, claim, demand, damage, cause of action, or loss of any kind as a result of my refusal to accept, receive, or allow emergency or medical services, including, but not limited to ambulance service, EMT, physician, or urgent care services.

NOTICE OF PRIVACY: I have been directed to read the *Notice of Privacy Practices* posted in the reception area.

AUTHORIZATION PAYMENT: I hereby sign all benefits to TOTAL BODY REHAB and also authorize release of any medical records necessary to facilitate my treatment, to process medical claims, and as otherwise permitted or required in the *Notice of Privacy Practices*. I understand fully that in the event that my insurance company or financially responsible for payment.

TREATMENT OF MINORS: I, as parent/guardian of a minor child receiving treatment, do agree and understand that I have been advised to remain in the office during any treatment, and waive any claim I may have resulting from the failure to do so.

INSURANCE DISCLAIMER NOTICE: All insurance information, both primary and secondary, must be disclosed at the initial visit. Failure to give complete and accurate information may result in a non-covered service being rejected by my insurance company, or may result in denial due to filing limitations and lack of authorization for services. I have provided this information, and it is true and accurate.

BENEFIT RELEASE AND SIGNATURE: I understand that the explanation of coverage has been obtained from my insurance company as a courtesy, and that it is NOT a guarantee of coverage. I do not hold TOTAL BODY REHAB responsible for any incorrect or omitted charges in my future coverage. If coverage is not a direct contract or if the information provided by my insurance is not accurate, or changes its coverage, I agree that I will be fully responsible for payment of services. I understand that I can verify my coverage information by contacting my insurance company's benefit department.

X _____ _____ _____

Patient, Parent, Legal Guardian Signature Date: Witness Signature

CONSENTS CONTINUED:

IMPORTANT SPLINT INFORMATION: At TOTAL BODY REHAB we make splints that are fabricated and molded specifically to fit you. The splints we make are for you and your condition per your doctor's orders. Because the splint is custom-made, there are no returns or reimbursements as they cannot be used for anyone else. CHARGES FOR SPLINTS MAY BE APPLIED TO YOUR ANNUAL DEDUCTIBLE. Cost for replacement splints (lost, stolen, or destroyed) will be the patient's responsibility to cover, as insurance does not usually cover splint replacements. I have read and understand this splint disclaimer.

X _____ _____ _____

Patient, Parent, Legal Guardian Signature Date: Witness Signature

HIPPA Consent: Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment or healthcare operations.

X _____ _____ _____

Patient, Parent, Legal Guardian Signature Date: Witness Signature

Printed Name: _____

May we contact to confirm appointment vis phone, email or text? YES OR NO

May we leave a message on your answering machine at home or on your cell phone? YES OR NO

PLEASE PROVIDE EMAIL ADDRESS: _____

How did you hear about us? PLEASE CHECK BELOW

☐ Website	☐ Friend/Family	☐ Google	☐ Facebook	☐ LinkedIn
☐ Yelp	☐ Twitter	☐ Instagram	☐ Dr. Ref	☐ Other