Witte PHYSICAL THERAPY

CONSENT TO TREATMENT

1. CONSENT TO TREATMENT
   I, knowing that I have a condition requiring diagnosis, treatment, or related care do hereby consent to such care, physical therapy examination, procedures, interventions, and/or treatment by a physical therapist, their assistants or aides, as may be necessary in their professional judgment. I further acknowledge that no guarantees have been made to me as to the results of such care, physical therapy examinations, procedures, and/or interventions. I also authorize release of such information to the third party payor(s).

1. ASSIGNMENTS OF BENEFITS
   I hereby assign to Witte Physical Therapy and to all therapists providing treatment(s) all right, title, and interest, in and to the benefits payable affording clinic and therapist's coverage. I direct that such benefits be paid directly to said clinic and therapists.

2. INSURANCE PRE-CERTIFICATION INFORMATION
   Many insurance companies have pre-certification requirements for physical therapy. If you are not sure whether your insurance company had pre-certification requirements, please check before evaluation and/or treatment so that you will not be denied insurance benefits for this/these visit(s).

3. AUTHORIZATION FOR RELEASE OF INFORMATION
   I hereby authorize Witte Physical Therapy to furnish records from any treatments, photocopies of such records and/or information, and excerpts from such records to the attending physician, his/her associates, and/or consultants, and third party payor (whether an insurance company, government agency, or self insured employer) and/or any transferee health care facility and/or agency for the purposes of obtaining payment for services rendered while under clinic care, performing utilization review, and/or post care and treatment. If this is a work related injury I authorize Witte Physical Therapy to provide my employer with any and all needed information related to my condition. Finally, if further care from another therapist, physician, or specialist were needed I authorize the release of my records to such a party.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING, AND IS THE PATIENT, OR IS DULY AUTHORIZED BY OR IN BEHALF OF THE PATIENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.
Responsible Patient/Party/Insured: ____

Responsible Patient/Party/Insured: ____

Witness: ____

Date and Time: ____

CONSENT TO TELEHEALTH

4. INTRODUCTION OF TELEHEALTH
   Telehealth is the delivery of healthcare services when the healthcare provider and the patient are not in the same physical location using technology. Electronically transmitted information may be used for diagnosis, therapy, follow-up, and/or patient education and may include patient medical records, medical images, interactive audio, video, and/or data communications, and output data from medical devices. The interactive electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

5. RISKS
   Risks may include, but are not limited to:
   - Information transmitted may not be sufficient to allow for appropriate medical decision making by the physical therapist or physical therapist assistant
   - The physical therapist or physical therapist assistant may not be able to provide medical treatment through the use of telehealth equipment nor provide for or arrange for any emergency care that may be required
   - Delays in evaluation and treatment could occur due to deficiencies or failures of equipment
   - Security protocols could fail causing a breach of privacy of personal medical information

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Responsible Patient/Party/Insured: ____

Responsible Patient/Party/Insured: ____

Witness: ____

Date and Time: ____

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CONSENT FOR MEDICAL PHOTOGRAPHY

I consent for medical imaging (phone, video, and/our audio) to be made of me, my child, or the person whom I am a legal guardian for. I understand that the information may be used in my/their medical record, for purposes of medical teaching at Witte Physical Therapy, or for publication in marketing tools in print or on Witte Physical Therapy social media accounts (Facebook, Twitter, Instagram). By consenting to this medical photography, I understand that I will not receive payment from any party. Refusal to consent to photographs, video, and/or audio recordings will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future, I may contact the staff at Witte Physical Therapy.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING, AND IS THE PATIENT, OR IS DULY AUTHORIZED BY OR IN BEHALF OF THE PATIENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

Responsible Patient/Party/Insured: ____

Responsible Patient/Party/Insured: ____

Witness: ____

Date and Time: ____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This form serves as an acknowledgement that you have received a copy of Witte Physical Therapy's Notice of Privacy Practices.

Please fill out the lines below and return to the front desk.

Signature: ____

Printed Name: ____

Date: _______________________________________

Circle any you have or may have:

Arthritis Osteoarthritis Rheumatoid Arthritis Osteoporosis Epilepsy Diabetes

Kidney Disease Liver Disease Rheumatic Fever Cancer: ___________________________

Stomach Ulcers Cortisone Drugs Heart Disease Chest Pain Anemia

High Blood Pressure Stroke/TIA Depression Polio Tuberculosis Asthma

Chronic Bronchitis COPD/Emphysema Peripheral Neuropathy Diabetic Ulcer

Peripheral Artery Disease Other: ____

Past Surgeries (Year):

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Medications:

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