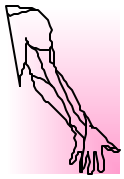
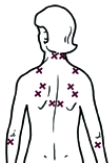
E-mail Print



Hilton Head Occupational Therapy

Consent to Care & Acknowledgement Form



I, _____ wish to have occupational therapy services provided for me by Hilton Head Occupational Therapy. By signing this document I am agreeing to the following:

1. I consent to the rendering of occupational therapy services by Hilton Head Occupational Therapy and its personnel according to my physician authorized plan of treatment.

2. I understand that treatment may involve risk of injury and of adverse results. I hereby acknowledge that no guarantees have been made to me as to the results of treatments which I may undergo while receiving occupational therapy services from Hilton Head Occupational Therapy personnel.

3. I consent to emergency treatment if and when physician or other medical personnel at Hilton Head Occupational Therapy deem necessary and appropriate.

4. I understand that Hilton Head Occupational Therapy is liable neither for accidents and/or injuries to me or others nor for loss of or damages to personal property while I am under the care of Hilton Head Occupational Therapy.

5. I understand that I have the right to consent or refuse to consent to any proposed procedure or therapeutic course of treatment. I may also terminate occupational therapy services at any time by notifying an employee of Hilton Head Occupational Therapy.

6. I hereby grant permission to Hilton Head Occupational Therapy to obtain and/or release medical and health records, information, and other necessary data regarding the above named patient, as needed to provide care and for Medicare and Insurance claims.

7. Assignment of Benefits: I hereby assign and authorize payment directly to Hilton Head Occupational Therapy for any occupational therapy benefits due Hilton Head Occupational Therapy from third parties for services rendered.

8. I certify that the information given by me in applying for payment is correct. If any of the information provided by me is incorrect, or if the third party insurance denies the claim, or if there are applicable deductibles or co-payments, I agree to be responsible for the payment for said services.

9. I understand that this consent is in effect until revoked by me.

_____ _____

Date Signature of Patient, Legal Representative or Agent

_____ _____

Date Signature of Owner, Operator,
Dr. Madeline Chatlain