EDELMAN SPINE & ORTHOPAEDIC PHYSICAL THERAPY
99 Wolf Creek Blvd., Suite 2
Dover, DE 19901

PATIENT CONSENT FORM

A. CONSENT TO TREATMENT

☐ I give permission to ESOPT to provide treatment to me based on their clinical expertise.

B. CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I _____(print name) hereby give consent to Edelman Spine & Orthopaedic Physical Therapy, LLC (ESOPT) and all health care providers furnishing care within ESOPT's facilities to use and disclose my protected medical and health information necessary for treatment, payment or healthcare operations purposes, as further described in ESOPT's Notice of Privacy Practices.

ESOPT's Notice of Privacy Practices provides more detailed information about the usage and disclosure of your protected health information. ESOPT reserves the right to amend the terms of the Notice of Privacy Practices. You have the right to review ESOPT's Notice of Privacy Practices before you sign this consent.

You have the right to request restriction on the usage and disclosures of your protected health information for the purposes of treatment, payment, or health care operations. ESOPT is not required to grant your request; however, if ESOPT does, the restriction will be obligatory to ESOPT.

You may cancel this consent at any time. The cancellation must be in writing, signed by you, and delivered to ESOPT at 99 Wolf Creek Blvd.,Suite 2, Dover, DE 19901. Your cancellation may be delivered in person or by mail, and will be effective the date it is received. The cancellation will not be effective to the extent that ESOPT or others have acted in reliance upon this consent.

I, HEREBY:

- ❑ CONSENT to Edelman Spine & Orthopaedic Physical Therapy's Disclosure Policy.
- ❑ DO NOT CONSENT to Edelman Spine & Orthopaedic Physical Therapy's Disclosure Policy. [1]
- ❑ I GIVE PERMISSION to Edelman Spine & Orthopaedic Physical Therapy to leave a message at the phone numbers I have provided.
- ❑ I GIVE PERMISSION FOR: Edelman Spine & Orthopaedic Physical Therapy to discuss my protected health information (PHI) with:
  - ❑ Name:_____
  - ❑ Relationship: _____
  - ❑ Phone #: _____

  - ❑ Name:_____
  - ❑ Relationship: _____
  - ❑ Phone #: _____

[1] By choosing to forfeit your consent of disclosure, ESOPT will be unable to bill your health insurance. Therefore, in order to commence or continue treatment you will be required to pay at the time services are rendered.

C. ASSIGNMENT OF BENEFITS/PAYMENT AUTHORIZATION

_____ **Assignment of Insurance Benefits**

Initials I authorize that the payment of my insurance benefits be made directly to Edelman Spine & Orthopaedic Physical Therapy for all services delivered; if I am paid directly, I will promptly pay Edelman Spine & Orthopaedic Physical Therapy all monies paid to me. I authorize the release of any medical information necessary to process claims.

_____ **Guarantee of Payment**

Initials I understand that all payments designated as 'the patient's responsibility' such as co-insurances and deductibles are due and payable at the time of service or statement receipt. I guarantee I will pay the amount deemed "my responsibility' by my insurer by the statement due date. I acknowledge that it is also my responsibility to obtain a referral from my referring physician if it is required or I will be responsible for payment of fees for services.

_____ **Certification of Information**

Initials I certify that the information I have provided Edelman Spine & Orthopaedic Physical Therapy for payment including, but not limited to, related accidents, illnesses or other insurers is accurate and truthful.

_____ **Financial Responsibility**

Initials ESOPT is authorized to take any legal action which may be necessary either in law or in equity in my name against any insurance company for any and all fee balances, and I agree to cooperate fully with ESOPT in the presentation of such claims and to furnish all papers and documents necessary in such proceedings. In the event of default on any payment due to ESOPT which are my responsibility, I agree to pay the cost of collection including attorney fees. Balances not paid within 60 days are subject to collection procedures and a collection fee.

AUTOMOBILE ACCIDENTS ONLY:

_____ **Health Insurance Option:**

Initials I agree to Edelman Spine & Orthopaedic Physical Therapy to file my health insurance within the required claims filing period should my personal auto or the other party's insurance deny the claim, exhaust the benefits or fail in any way to pay per the agreed upon terms.

D. ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

❑ By checking this box, I acknowledge that I have been offered a copy, at my request, of the Notice of Privacy Practices for Edelman Spine & Orthopaedic Physical Therapy, LLC. I recognize that outside of purposes for treatment, for payment, for certain healthcare operations or as permitted or required by law, I must give my written authorization to Edelman Spine & Orthopaedic Physical Therapy to release any of my protected healthcare information.

IN WITNESS WHEREOF, and intending to be legally bound, the undersigned has executed this Patient Consent form as of the day and year stated below.

_____ _____

Patient/Legal Representative Name (Print) **Patient/Legal Representative (Signature)**

Date:_____