**JERSEY CENTRAL PHYSICAL THERAPY**
**2147 Route 27**
**Edison NJ 08817**
**732-777-9733**

## INFORMED CONSENT TO TREAT

I hereby request and consent to the treatment of occupational and/or physical therapy on me by the physical and/or occupational therapists at Jersey Central Physical Therapy.

I have had an opportunity to discuss with the therapist the nature and purpose of the therapy and other procedures. I understand that results are not guaranteed.

I wish to rely upon the therapist to exercise judgment during the course of the procedure which the therapist feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content with my therapist, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition.

I understand that Jersey Central Physical Therapy has been selected as a clinical education site for a variety of physical and/or occupational therapy programs and that from time to time, there may be therapy students that participate in my care.

## PATIENT INFORMATION ACKNOWLEDGEMENT

I have read and fully understand the Company's Notice of Information Practices. I understand that the Company may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the obtaining the quality of services provided and any administrative operations related to treatment or payment. I also understand that it is the Company's policy to send reports to my primary care physician, my referring physician and other physicians associated with my care. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice in writing. I also understand that the Company will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for the purposes as noted in the Company's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the Company in writing.

## DESIGNATED INDIVIDUALS AUTHORIZATION

I hereby authorize on or all of the designated parties listed below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of the designated parties must be verified before the release of any information.

Authorized Designees:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date