Dr. Steven S. Goldberg, MD - Physical Therapy

Orthopedics and Sports Medicine Rehabilitation

INFORMED CONSENT

I understand that Dr. Steven S. Goldberg's Office will maintain my privacy to the highest standards and may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.

I give my consent Dr. Steven S. Goldberg's Office to evaluate my condition and furnish physical therapy treatment as considered necessary and proper by the Physical Therapist, through its appropriate personnel, agents and affiliates to perform the evaluation, care and treatment procedures that are deemed necessary by my physician(s) and other healthcare providers and Physical Therapist.

Patients/clients need to know:

● The purpose of any examination/assessment or intervention/treatment
● Any risk associated with the proposed intervention/treatment
● The expected benefit of the intervention/treatment
● Reasonable alternatives to the proposed intervention/treatment
● I understand that no warranties or guarantees have been made to me about the outcome of my Care.

Patients/clients have the right to:

● physical therapy services without discrimination
● services provided by physical therapists who are free to make clinical and ethical judgments without outside interference according to their education and experience
● request a second opinion from another physical therapist at any stage
● physical therapy services provided in accordance with their best interests
● choose freely and change their physical therapist or health service institution
● decline examination/assessment and intervention/treatment at any stage, without it prejudicing future management
● receive information about themselves recorded in their health records
● receive information about practice policies, charges for services, physical therapy goals, desired outcomes and procedures
● choose who, if anyone, should be informed on their behalf
● discuss the physical therapy intervention/treatment options, benefits, risks and side effects

ACKNOWLEDGEMENT OF PATIENT RIGHTS & INFORMED CONSENT **Initial _____**

RELEASE OF MEDICAL INFORMATION

Dr. Steven S. Goldberg's Office uses your personal health information primarily for treatment; obtaining payment of treatment; conducting internal administrative activities, and evaluating the quality of care that we provide. For example, Dr. Steven S. Goldberg's Office, may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you. Dr. Steven S. Goldberg's Office, may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law. In any other situation, Dr. Steven S. Goldberg's Office Physical Therapy's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization through a written statement to stop future disclosures at any time. Dr. Steven S. Goldberg's Office, may change its policy at any time.

I authorize Dr. Steven S. Goldberg's Office to release any medical information about me to my insurance company or worker's compensation carrier for the processing of any medical claims filed on my behalf. I also authorize to release, receive, and/or discuss my medical information with any other medical provider(s) who have, are, or will be participating in my medical care.

RELEASE OF MEDICAL INFORMATION **Initial _____**

I authorize Dr. Steven S. Goldberg's Office to speak to the following person(s) regarding my medical care, treatment, and/or billing information:

(1) Name:_____, phone number: _____, and

relationship: _____

(2) Name:_____, phone number: _____, and

relationship: _____

I understand that I have the right to revoke this authorization at any time.

RELEASE OF MEDICAL INFORMATION **Initial _____**

HIPAA Acknowledgement

I acknowledge that I have received the practice/clinic's Notice of Privacy Practice/clinics, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice/clinic's Notice of Privacy Practice/clinics.

Initial _____

DIGITAL IMAGES AND VIDEOS

I understand that photographs and digital videotapes may be recorded to document my care and consent to this. I understand that Dr. Steven S. Goldberg's Office retains ownership rights to these digital images/videos but I will be able to request a copy. Images that identify me will be released and/or used outside of Dr. Steven S. Goldberg's Office only upon written authorization from me or my legal representative only if they are released for purposes other than treatment, payment, or healthcare operations. Photographs may be taken during initial evaluation, progress evaluation and discharge summary. By signing below I consent to the use of these photographs and in a professional manner. I understand that I am not permitted to take pictures or make video or audio recordings at any Dr. Steven S. Goldberg's Office location or clinic or of my care, other patients or Dr. Steven S. Goldberg's Office personnel.

Initial _____

Consent to mail, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications

We want to stay connected with our patients. Patients in our practice/clinic may be contacted via email, calls to your cellular telephone (including prerecorded/artificial voice messages and/or calls from an automatic dialing device), and/or text messaging to confirm an appointment, to obtain feedback on your experience with our healthcare team, and to be provided general health reminders/information. If at any time, you provide an email, cellular telephone number, address or text number below, you understand that you may get these communications from the Practice/clinic. You may opt out of these communications at any time with written consent. The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

● I authorize to receive text messages and/or cellular telephone calls for appointment reminders, feedback, and general health reminders/information and the cell phone number is: _____

Initial _____

● I authorize to receive email messages for appointment reminders and general health reminders/feedback/information and the email that is_____

Initial _____

CANCELLATION / NO SHOW POLICY

I hereby acknowledge that I have reviewed Dr. Steven S. Goldberg's Office – Physical Therapy NO SHOW, CANCELLATION & LATE ARRIVAL policy and I understand a $50 fee will be charged to me for each appointment I do not give a 24- hour notice and/or for each appointment I am more than 15 minutes late that results in a same day cancelation.

CANCELLATION/NO SHOW POLICY **Initial _____**

PAYMENT POLICY

Payment, in the form of cash, check or credit card, is due at the time of each visit.

RESPONSIBILITY FOR PAYMENT: All co-payments are due at the time of service. I acknowledge that in consideration of the services provided to me by Dr. Steven S. Goldberg's Office, I am financially responsible for payment of my bill. I acknowledge that it is my responsibility to provide Dr. Steven S. Goldberg's Office with current insurance information and to familiarize myself with my insurance plan and its policies. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan. My health insurance plan may provide that a portion of the charges and balance will remain my personal responsibility, such as my deductible, co-payment, co-insurance or charges not covered or denied by my health insurance, Medicare, or other programs for which I am eligible.

We are not contracted with all insurance companies. However, the payments you make may be reimbursable by your insurance company under your out of network physical therapy benefits; the exact percentage depends upon your plan. Due to the complex nature of insurance claims and reimbursement, I make no promises as to whether you will receive reimbursement.

DIRECT PAYMENT NOTIFICATION: Arizona state constitution permits you to pay a healthcare provider for health care services directly. If you elect to use cash based or direct payment, full payment is expected at time of service.

- We will assist you in every way possible.
- Payment is due at the time of service.

AKNOWLEDGEMENT of PAYMENT POLICY **Initial _____**

It is expressly agreed that all exercises and treatments and use of all facilities shall be undertaken at the patients/ members own risk, and the member represents that he/she is physically able to understand and and all physical exercises and treatments provided Dr. Steven S. Goldberg's Office shall not be liable for any claims, demands, injuries, damages, actions, or causes of action whatsoever to the member/ patient arising out of, or connected with the use of any of the services, and/or facilities.

Patients/ Member does hereby expressly forever release and discharge Dr. Steven S. Goldberg, MD and any of his Office staff members/employees attended and / or all of their affiliated companies from all such claims, demands, injuries, damages, actions or causes of section, and from all facts of active or passive negligence on the part of such companies, corporations, clubs, studios, their servants, agents, or employees

I do hereby agree and give my consent for Dr. Steven S. Goldberg's Office – Physical Therapy Department to furnish care and treatment that is considered necessary and proper in the diagnosing or treating of my physical condition.

I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

I hereby certify that all the above information is true to the best of my knowledge.

I have read and understand the above policies.

Name (print):_____

Signature: _____

Date: _____