Hillcrest
PHYSICAL THERAPY & WELLNESS
Optimum Results, Healthy Living

Client Information and Consent

Privacy Notice

I have read and fully understand the Hillcrest Physical Therapy & Wellness Notice of Privacy Practices. I understand that Hilcrest Convalescent Center, Inc. d/b/a "Hillcrest Physical Therapy & Wellness" may use or disclose my personal health information for the purpose of carrying out treatment or receiving payments. I understand that I have the right to restrict how my personal health information is used and disclosed for treatments, payment, and administrative operations if I notify the office.

I hereby consent to the use and disclosure of my personal health information for the purposes noted in the Hillcrest Physical Therapy & Wellness Notice of Privacy Practices. I understand that I retain the right to revoke this consent by notifying the office in writing at any time.

Consent for Evaluation and Treatment

I am aware of my diagnosis, and voluntarily consent to have Hillcrest Physical Therapy & Wellness, through its appropriate personnel, provide evaluation and/or treatment as prescribed by my physician and/or recommended by my therapist. I understand that the practice of physical therapy is not an exact science, and I acknowledge that no guarantees have been given to me regarding the successful completion or the results of the treatment provided. I understand that the treatment I receive from Hillcrest Physical Therapy & Wellness is limited to physical therapy services and that I shall seek treatment from other medical professionals for all other issues I may experience. I understand that I have the right to ask questions at any time during the course of my care. I hereby give permission for treatment, evaluation, and therapy by Hillcrest Physical Therapy & Wellness.

Authorization to Pay for Services/Agreement of Insurance Coverage

I hereby authorize Hillcrest Physical Therapy & Wellness to release medical information necessary to process insurance claim(s) on my behalf of services rendered. I request payment of any medical insurance be made directly to Hillcrest Physical Therapy & Wellness. I understand that if Hillcrest Physical Therapy & Wellness does not accept my insurance, I will be responsible for making payments directly to Hillcrest Physical Therapy & Wellness. I understand I will be responsible for any out of network coverage charges or co-pay expenses. If my insurance denies payment to Hillcrest Physical Therapy & Wellness, I understand that I will be responsible for payments or charges not covered by my insurance.

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Client Name

_____ _____

Signature of Client Date

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Durham, NC 27707
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Fax 919-627-6627