



CONSENT FOR CARE

Effective Date: July 31, 2003

This Consent for Care allows EXCEL Therapy Specialists, LLC to provide evaluations and/or treatment of my condition by therapists employed by or under contract with EXCEL Therapy Specialists, LLC.

1. I understand there are certain risks involved in any exercise and/or therapy program. These risks may include musculoskeletal soreness, elevated heart rate, increased breathing, sweating or light-headedness. I acknowledge these risks and declare myself physically able to participate in my treatment. I take personal responsibility for reporting to the therapist any unusual signs or symptoms.
2. I will take personal responsibility to report to the therapist any new diagnosis, injuries or surgical procedures occurring during my treatment plan at EXCEL Therapy Specialists, LLC.
3. I understand that should I have any questions during my course of therapy that those questions should be directed to my treating therapist who will answer the questions to the best of their ability.
4. In most cases, physical therapy and/or occupational therapy is effective in reducing a patient's symptoms; however, there are instances where an existing condition may be aggravated.

I do hereby release EXCEL Therapy Specialists, LLC officers, employees, agents or students of any and all liabilities related to injuries or accidents which may occur as a result of participation in physical/occupational therapy at this facility and any medical bills that I may incur as a result of such injury or accident at EXCEL Therapy Specialists, LLC are my sole responsibility.

I ACKNOWLEDGE THAT I READ THIS WAIVER OF LIABILITY AND I WILL COMPLY WITH THE EXERCISE AND EVALUATION PROGRAMS DESIGNED BY THE PHYSICAL/OCCUPATIONAL THERAPIST.

Signature of Patient or Legal Guardian: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

This acknowledgement, which allows EXCEL Therapy Specialists, LLC to use and/or disclose personally identifiable health information for treatment, payment or healthcare operations, is a requirement of the federal privacy regulations for the Health Insurance Privacy and Accountability Act (HIPAA) of 1996.

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by EXCEL Therapy Specialists, LLC for the purposes of treating, obtaining payment for treatment and in order to carry out any healthcare operations that are permitted by this Act.
2. I am aware that EXCEL Therapy Specialists, LLC maintains a Privacy Notice regarding the types of used and disclosures that are permitted to be made under the Privacy act. By signing this acknowledgement, I understand that I have received a copy of the Privacy Notice.
3. I understand and acknowledge, EXCEL Therapy Specialists, LLC has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to submit a written request to EXCEL Therapy Specialists, LLC, 2234-B West Houston, Broken Arrow, OK 74012, Attention: Office Manager.
4. I understand and acknowledge that I have the right to request the EXCEL Therapy Specialists, LLC how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that EXCEL Therapy Specialists, LLC is not required to agree to restrictions requested by me.

I request the following restrictions placed on EXCEL Therapy Specialists' use and/or disclosure of my health information (leave blank if no restrictions are requested at this time):

I ACKNOWLEDGE THAT I HAVE REVIEWED A COPY OF THE EXCEL THERAPY SPECIALISTS' NOTICE OF PRIVACY PRACTICES AND AGREE TO EXCEL THERAPY SPECIALISTS' USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS.

Signature of Patient or Legal Guardian: _____ Date: _____