PATIENT CONSENT FORM

Medical Record #: _____

Patient Name: _____

CONSENT TO TREATMENT

I consent to rehabilitation and related services at Metro Hand Therapy. I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touch and /or direct contact of a sensitive nature. **Initials: _____**

AUTHORIZATION OF PAYMENT

I hereby assign all benefits directly to Metro Hand Therapy. When services are provided without insurance, payment will be provided prior to service. I also authorize release of my medical records to other healthcare providers as necessary to facilitate my treatment and to other third parties as necessary to process medical claims and otherwise permitted or required in the Notice of Privacy Practices. **Initials: _____**

LIABILITY

I know and agree that Metro Hand Therapy is not responsible for loss or damage to personal valuables. **Initials: _____**

WAIVER AND RELEASE

I hereby release, discharge and acquit Metro Hand Therapy from any and all liability, claim, demand, damage, cause of action or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and/or medical services including but not limited to ambulance service and urgent care services. **Initials: _____**

NOTICE OF PRIVACY / PATIENT BILL OF RIGHTS

I acknowledge receipt of Notice of Privacy Practices. **Initials: _____**

I acknowledge receipt of the States of Patient Rights. **Initials: _____**

PHOTO CONSENT

I grant permission to Metro Hand Therapy for the use of photograph(s) or electric media images. I understand that I may revoke this authorization at any time by notifying Metro Hand Therapy via writing and/or email. The revocation will not affect any actions taken before the receipt of this written notification. Images will be stored in a secure location and only authorized staff will have access to them. They will be kept as long as they are relevant and after that time destroyed or archived. **Initials: _____**

I certify that all of the information provided herein is true and correct.

Patient / Guardian Signature _____

Witness Signature _____