PHYSICAL THERAPY LYMPHATIC & WELLNESS CENTER
1531 Tamiami Trail Suite 702B
Venice, Florida 34285
Ph :(941) 493-4870
FX: (941) 493-4865
Physical Therapy
Lymphedema Therapist
Vestibular Rehabilitation
Myokinestic / Pain Management Specialist

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECIEPT OF NOTICE:
Health Insurance Assignment of Benefits:

Patient Name: _____ **D.O.B**_____

Patient Address: _____ **Patient's Phone Number:** _____

I have reviewed the Physical Therapy Lymphatic & Wellness Center (Issa Rehab Services Corp.) Notice of Privacy Practices and understand that it describes how medical information about me may be used/disclosed, as well as how I can access information.

Signature of Patient or Guardian: _____ **Signature of Witness:** _____

Date: _____

Insurance Company: _____ **Policy Number:** _____

Name of Policy Holder:_____ **Name of Patient:** _____

Employer (Under Group Coverage): _____

I hereby direct the above insurance company to pay to _____
All benefits for covered Physical Therapy treatments provided by said company. I understand that I will remain financially responsible _____ for charges for all services furnished by _____ to the extended not covered or paid by the above named insurance company.

As of services not covered or paid by the insurance company, I understand that unpaid accounts will be in default after 60 days from the date of invoice, after which a default charge will be imposed at 1 ½ percent per month on unpaid balances (18% annual percentage rate) or the maximum legal interest rate, whichever is lower. I agree to pay the default charge together with reasonable attorney's fees and all costs of collection.

Signature of Patient or Guardian: _____ **Signature of Witness:** _____

Date: _____ Rev/10/14

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CONSENT AND ASSIGNMENT FORM

Patient Name:_____ **Service Site**:_____

Consent for Treatment and Patient Bill of Rights

On this date_____ (dd/mm/yy) I authorize Physical Therapy Lymphatic and Wellness Center (DBA) (Issa Rehab Services Corp.) to perform the physical therapy, occupational therapy and /or treatment that it considers necessary for my care. I agree to work with Physical Therapy Lymphatic and Wellness Center (DBA) (Issa Rehab Services Corp.) to maximize my progress toward mutually established treatment goals, which have been authorized by my physician.

Indicate the SOC for each discipline authorized:
PT/SOC: _____
OT/SOC:_____

Release of Information, Assignment of Benefits, and Financial Liability

I intending to be legally bound, authorize Physical Therapy Lymphatic and Wellness Center (Issa Rehab Services Corp.) and it's representatives to share records and information with third parties participating in my Rehab, including any party through which insurance program or otherwise is paying for all or part of my Rehab. I authorize Physical Therapy Lymphatic and Wellness Center (Issa Rehab Services Corp.) to act on my behalf with any reasonable and necessary appeals in regard to services provided by Physical Therapy Lymphatic and Wellness Center (Issa Rehab Services Corp).
I authorize payment of medical benefits by any third party payer to be made directly to Issa Rehab Services Corporation. For any Rehab services rendered to me. I, the patient, understand that I am financially responsible, as required by federal, state, and insurance company regulations, for any benefits not covered by health insurance/third party payor.

Verbal Consent Given By: _____

Patient Representative's Phone Number: _____

Witnessed By: _____ and _____

Date Consent and Assignment Form mailed to Patient Representative: _____

I warrant that I have read the Consent for Treatment above and have received a copy of the Patient Bill of Rights.

Signature: _____

If any of the above is signed by an authorized representative due to incapacity of the patient, what is the relationship of this representative to the patient?_____

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Medical Records Release Form:

To Dr: _____ Date: _____

I hereby authorize you to release my medical records, specifically:

_____ Findings of medical care _____ Lab/X-ray reports

_____ Alcohol or drug abuse information _____ Psychiatric/Psychological care/exam

_____ Clinic notes _____ Diagnosis

_____ Treatment _____ Surgery notes

_____ Other (_____)

As they apply to me during the period from _____ to _____, or specific information related to:

These records are to be sent/faxed to:

Patient Name: _____ **D.O.B**_____

Patient Address: _____ **Patient's Phone Number:** _____

Signature of Patient or Guardian: _____ **Signature of Witness:** _____

Date: _____

Rev 10/14

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Photography/Video/Social Media Release Form

I _____, hereby give (DBA) Physical Therapy Lymphatic and Wellness Center (Issa Rehab Services Corporation) the absolute and irrevocable right to take and permission to use photographs of me and or personal written statements or in which I may be included with others.

a) To copyright the same in said organization's own name or name that they may choose , and/or
b) To use re-use, publish and republish the same in whole or in parts, individually or in conjunction with other photographs , in any medium/internet or web purposes and for the purpose of medical information of the public, medical staff of clinic employees, including but (but not by the way of limitation) illustration, promotion, and advertising and trade, and/or
c) To use my name in connection therewith if they choose: YES: ___ or NO:____
d) Restrictions:_____No Facial Photographs:_____
Other:_____
e) The ability to use video, photographs, and written text on social media outlets such as: Facebook, Twitter, LinkedIn, Google Plus, and Tumblr.

I hereby release and discharge Physical Therapy Lymphatic & Wellness Center, (Issa Rehab Services Corp) from any and all claims demands arising out of or in conjunction with the use of photographs, including but not limited to any and all claims of libel, invasion of privacy, etc.

This authorization and release shall also ensure to the benefit of the legal representatives, licenses and assigns of Issa Rehab Services Corporation, (DBA) Physical Therapy Lymphatic and Wellness Center.

I am over the age of 18, and have read the foregoing and fully understand the contents thereof.

Adult Release:
Patient Name: _____ **D.O.B**_____

Signature: _____

Date: _____

Minor Release:
Patient Name: _____ **D.O.B**_____

Signature: _____ **Relationship to Subject**: _____

Date: _____