PINNACLE
PHYSICAL THERAPY

650 Hawkins Ave, Suite 4 PH (631)981-7422
Ronkonkoma, NY 11779 FX (631)981-2490

PATIENT CONSENT

This consent is given to the healthcare provider named below to use and disclose my individually identifiable health information for specific purpose of:

- Obtaining payment from my health insurance plan or other responsible payer
- Providing the appropriate treatment
- Performing permissible healthcare operations

These specific uses and disclosures are permitted under the administrative simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) and under New York Privacy Regulations.

I have been informed by you of your "Notice of Privacy Practices," containing a complete description of the uses and disclosures of my health information. I have been given the right to review such notice prior to signing this consent. I understand that this establishment has the right to change it's, "Notice of Privacy Practices," from time to time and that I may contact this organization at any time, at the address indicated above, to obtain a current copy of the, "Notice of Privacy Practices."

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide to such restrictions.

I have the right to revoke this consent in writing at any time, except to the extend that you have taken action relying on this consent.

Patient Name: _____

Patient Signature: _____ Date: _____

HEALTH CARE PROVIDER: Pinnacle Physical Therapy (formerly Premier Physical Therapy)

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MISSED APPOINTMENT / CANCELLATION POLICY

In order to be respectful of the medical needs of fellow patients, please be courteous and contact our office promptly if you are unable to attend an appointment. If it is necessary to cancel your scheduled appointment we require that you call 24 -hours in advance. Patients may be subject to a $45 fee for missed / no show appointments.

Your signature below only indicates our staff has made you aware of our policy. It has no impact whether or not you will or will not be billed.

☑ **I acknowledge that a 24-hour cancellation is required to respect other patients who may be in need of the appointment, as well as the therapist's time.**

☑ **I acknowledge that a missed appointment will be subject to a $45.00 fee.**

_____ _____
Patient Signature Date

**** PLEASE NOTE; refusal to sign above does not indicate whether you will or will not be billed ****