Occupational & Hand Therapy Specialists, Inc.

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Consent to Treat Form / Acknowledgement & Authorization of HIPAA Privacy Practices

The patient authorizes the Occupational Therapist to examine and treat the condition as he/she deems appropriate through the use of occupational therapy measures, and the patient gives the authorization for these procedures to be performed.

The patient has the right to informed participation in decisions involving his/her health care. This shall be based on clear, concise explanation of his/her condition and of all proposed treatment procedures. All possible risks and/or side effects as well as the probability of success with such procedures shall be disclosed to the patient by his/her attending Occupational Therapist. The patient will not hold the Occupational Therapist responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. The patient has the right to know who is responsible for authorizing and performing any and all treatment procedures. The patient shall not be subjected to any procedure without his/her voluntary, competent, and understanding consent or the consent of his legally authorized representative. Where medically significant alternatives for care or treatment exist, the patient shall be so informed.

The patient shall be advised if *Occupational & Hand Therapy Specialists, Inc.* (OHTS) proposes to engage in or perform human experimentation, for the purpose of research, affecting his/her care. The patient has the right to refuse to participate in such research projects.

I acknowledge that I have been informed of and/or provided with the "Notice of Protected Health Information Practices" form:

- This notice describes how medical information about me may be used and disclosed and how I can get access to this information.
- The Notice explains in more detail how OHTS, Inc. may use and share my health information for other than treatment, payment, and health care operations.

OHTS, Inc. will only use and share my health information as required/permitted by law

I have read (or have had read to me) the above information and understand the content. I hereby consent to receive occupational therapy at Occupational & Hand Therapy Specialists, Inc., to begin on this date and terminating when determined by myself, my physician or my Occupational Therapist.

X_____ _____
Patient/Guardian Signature Date

X_____ _____
Witness Signature (OHTS, Inc. office staff) Date

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If you would like to receive appointment reminders via email, please list your email below:

Email: _____

EMERGENCY CONTACT:

Name: _____ Relationship: _____
Home Phone: _____ Cell Phone: _____

***To be completed for ALL WC PATIENTS**:*

I authorize OHTS, Inc. to release information regarding my care to the following individuals:

Adjustor Name: _____ Phone #: _____
Nurse Case Manager: _____ Phone #: _____