Child Name/Caregiver Name:

Address:

Insurance Carrier and ID#

Social Security #

Responsible Party for Patient:

Patient Primary Care Physician

CONSENT TO RECEIVE SERVICES:

I hereby authorize **PEDIATRIC PHYSICAL THERAPY OF HAWAII** to render Physical Therapy services to _____. I recognize and agree that I have a right to refuse treatment or terminate services at any time by notifying **PEDIATRIC PHYSICAL THERAPY OF HAWAII** within 2 days of my decision. In addition, **PEDIATRIC PHYSICAL THERAPY OF HAWAII** may terminate services by notifying me of termination within 2 days of decision. I also understand that no guarantees have been made to me regarding the results of treatment. The type and extent of services that will be rendered will be determined following initial assessment and through discussion with me.

I understand that information regarding care is confidential. However, I acknowledge that there are exceptions to this confidentiality that include the following:
When there is risk of imminent danger to the patient or another person, **PEDIATRIC PHYSICAL THERAPY OF HAWAII** is ethically bound to take necessary steps to prevent such danger.
When there is suspicion that a patient is being sexually or physically abused or is at risk of such abuse, **PEDIATRIC PHYSICAL THERAPY OF HAWAII** is legally required to take steps to protect the patient and to inform proper authorities.
When a valid court order is issued for medical records, **PEDIATRIC PHYSICAL THERAPY OF HAWAII** is bound by law to comply with such requests.

RELEASE OF MEDICAL RECORDS:

I hereby consent and request that copies of my prior medical and/or diagnostic record be delivered to **PEDIATRIC PHYSICAL THERAPY OF HAWAII** if necessary to establish or continue my health care plan. I hereby authorized **PEDIATRIC PHYSICAL THERAPY OF HAWAII t**o release copies of my medical/therapy records, or such portions thereof as may be relevant, or reports of summaries thereof, to other heath care provider or facilities for the purpose of continuing and coordinating my plan of treatment. Additionally I give permission to release information for any treatment/care is authorized for my insurance or other payer. I understand that **PEDIATRIC PHYSICAL THERAPY OF HAWAII** will maintain my medical record for a period of 5 years. I can request copies of medical records at any time during this period.

PATIENT SIGNATURE:

I have read and fully understand the content of this consent and release and hereby agree to and authorized the foregoing provision. As used in this document, the terms "I", and "me", and "my" refers to and include, in addition to the undersigned, the patient named above and other from whom the undersigned is responsible, or, for, whom the undersigned has assumed responsibility in engaging **PEDIATRIC PHYSICAL THERAPY OF HAWAII** to provide services to the patient.

I understand that I may withdraw the consent on writing. My withdrawal will not be effective for actions already taken by **PEDIATRIC PHYSICAL THERAPY OF HAWAII**, or in process. This consent shall be effective as long as the business relationship continues. This agreement shall renew itself annually unless otherwise terminate by either party.

Authorized Representative Printed Name	**Witness or Therapist Signature**
Authorized Representative Signature	**Date**