Name:	Medical Record No:

CONDITIONS OF ADMISSION TO
SPECTRUM PHYSICAL THERAPY & ATHLETIC TRAINING, LLC.
OUTPATIENT SERVICES

1. **CONSENT TO TREATMENT:** I understand that I am being admitted for treatment to an outpatient department of Spectrum Physical Therapy & Athletic Training, LLC. ("Spectrum"), an acute care rehabilitation center. Consent is hereby voluntarily given to Spectrum and to all health care professionals using its facilities to provide comprehensive and therapeutic treatments and/or evaluations that, in the judgment of the appropriate health care professionals, are necessary for the health and welfare of the above named patient.
2. Absent emergency or extraordinary circumstance, no substantial procedures will be performed upon me unless and until I have had an opportunity to discuss them with the physician or other health professional to my satisfaction. I or my representative will be informed of the nature of the particular procedure or treatment which a physician in a similar circumstance would reasonably disclose, which would provide a reasonable individual; with a general understanding of the procedure or treatment, possible alternative procedures and treatments and substantial risks inherit in the proposed procedure and which a patient in my circumstances would consider relevant in making a decision concerning whether to undergo the treatment or procedure.
3. **RESEARCH:** Research to improve patient care is conducted at this clinic and is approved and monitored by members of Spectrum. This review and monitoring assures strict confidentiality with regard to who may view medical records. I consent to the use of in formation in my record for research purposes. I understand that I might subsequently be asked if I would be willing to participate in research projects if they require activities outside of normal clinical care, and that I have the right to decline participation.
4. **RELEASE OF INFORMATION:** I understand and agree that Spectrum may disclose all or any part of a patient's record in order to obtain payment of all or a part of Spectrum's charges. This disclosure may be made by Spectrum to any person or corporation which is or may be liable under a contract with Spectrum, the patient, a family member or employer of a patient, including but not limited to insurance companies, governmental agencies (including Medicare and Medicaid), worker's compensation carriers, welfare funds, the patien t's employer and other third party payors. I understand and agree that Spectrum may disclose all or any part of patient's record to other providers of health care services or goods in order to make arrangements for coordinated health care delivery. I understand and agree that the information, which Spectrum may disclose, may include information about and/or reference to HIV/AIDS related diagnoses/condit ions, drug and alcohol use or abuse, pain management, and psychiatric or psychological information, reports, ev aluations and diagnoses, as well as evaluations, consultations, and treatment recommendations. Spectrum may disclose medical information about a patient to the patient's physician (noted in the admission record), and to: Spectrum personnel who are authorized to disclose patient information include members of the medical records department, finance department, and clinical personnel (including physicians, nurses, therapists). I understand that I have the right to change my mind regarding release of information from my medical record at any time, by sending a written notice to the Director of Medical Records but this will not affect information, which has already been released. I am aware that confident ial communications between a patient and a licensed psychologist/ psychiatrist are protected by statutory privilege accorded by section 28 of the Public Law 1966, chapter 282 to confidential communications between a patient and a licensed psychologist/ psychiatrist and c annot be released without my consent. If I do not notify the Director of Medical Records that I am revoking this consent to release information, this consent will terminate one (1) year after payment in full has been made to Spectrum for all goods and services provided to me .
5. In the event of a health care worker's accidental exposure to my blood or other body fluids, I hereby authorize the clinic with the assistance from personnel certified to take blood, to draw a blood sample for the presence of blood borne pathogens, includin g HIV (AIDS), and / or Hepatitis B or C. The results of such tests will remain confidential.
6. **PERSONAL RESPONSIBILITY:** In the event that payment from my insurance companies and/ or benefits plan is insufficient to cover the cost of my treatment at the clinic, I understand that if no payment is made by the insurance companies and/or health benefit plans, I am responsible for payment of the entire charge for treatment provided during visits to the Spectrum clinic. I understand that if I do not pay the entire within (30) thirty days after the date I may be billed, a charge of one percent (1%) of the total balance on the account may be a dded to the account for that billing period and each month thereafter until the balance is paid in full. I further understand that in the event that Spectrum retains the services of a collection agency or an attorney due to my failure to pay the balances due within (30) day s after a demand for payment, that I am responsible for the actual costs incurred by Spectrum for these services, not to exceed thirty percent (30%) of the total outstanding balance on the account.
7. I authorize Spectrum to apply and credit any overpayment made to Spectrum which would be payable to me against any balance owed to Spectrum for Which I am the responsible party. I irrevocably assign to Spectrum all the right, title, and interest in benefits payable for injuries to me which are being treated by Spectrum out of any claim or third party action against any other person, entity, o r insurance company or out of any recovery under the uninsured motorist provisions or the medical payment provision of any insurance polices under which I may be entitled to recover for injuries which are being treated by Spectrum. Co-payments are due at the time of service.
8. I acknowledge receipt of the Spectrum Notice of Privacy Practices and Patient's Rights.

This form has been fully explained to me and I certify and acknowledge that I understand its contents and agree its terms and provision.

_____ _____
Patient Name Signature

_____
Signature of Parent or Guardian (if under 18) Date _____/_____/_____