



1420 Ashley Rd  
Boonville MO 65233

Phone 660-882-6115  
Fax 660-882-6120

### **CONSENT FOR TREATMENT**

I recognize that I am suffering from a condition requiring athletic training and/or physical therapy services and treatment. I hereby consent to the rendering of athletic training and/or physical therapy services by Excel Physical Therapy & Sports Medicine Clinic, P.C., as described to me or as my physician or Excel Physical Therapy & Sports Medicine Clinic, P.C. determines are necessary. I understand that the practice of athletic training/physical therapy is not an exact science and that athletic training/physical therapy treatment involves the risk of injury or even death. I acknowledge that no guarantees have been made to me about the outcome of treatment.

### **CONSENT OF DISCLOSURE**

(For the Usage and/or Disclosure of Protected Health Information)

I hereby give consent to Excel Physical Therapy & Sports Medicine Clinic and all health care providers furnishing care within Excel Physical Therapy & Sports Medicine Clinic to use and disclose my protected health information for the purposes of treatment, payment, and health care operations.

You may cancel this consent at any time. Your cancellation must be in writing, signed by you or on your behalf, and delivered to the address listed above. This may be delivered in person or by mail, but will only be effective when actually received. Your cancellation will not be effective to the extent that others or we have acted in reliance upon this consent.

You have the right to request restriction on the usage and disclose of your protected health information for the purposes of treatment, payment, or health care operations. We are not required to grant your request, if we do, the restriction will be obligatory to us.

Our Posted Privacy Policy provides more detailed information about the usage and disclosure of your protected health information. You have the right to review our Posted Privacy Policy before you sign this consent.

We reserve the right to amend the terms of our Posted Privacy Policy. You may obtain a copy of the current policy by: 1) viewing the copy that is available in our waiting room, 2) by going to our web site [www.excelpt.net](http://www.excelpt.net), and 3) by asking for a copy from our Privacy Officer, Jill McCormick, PT, ATC.

**(Over)**

**ASSIGNMENT OF INSURANCE BENEFITS**

I hereby assign Excel Physical Therapy & Sports Medicine Clinic, P.C., (1) all insurance, Medicare, Medicaid, and other private or governmental benefits payable for my treatments and care; and (2) all rights to payment and all money paid for any claim related to the reasons for which I am being given athletic training or physical therapy service and treatment. Anyone paying or receiving money for my benefits or claims shall pay the money directly to Excel Physical Therapy & Sports Medicine Clinic, P.C., for payments of my bills. I understand that I am financially responsible for all charges not covered by my insurance or other third party payers and that any balance after insurance or third party payment has been made is due within thirty (30) days.

I have read and understand this form and the program it describes, and I do voluntarily request the right to participate in Excel Physical Therapy & Sports Medicine Clinic’s rehabilitation program. I do hereby discharge, release, and hold harmless Excel Physical Therapy & Sports Medicine Clinic and any if it’s personnel participating in this rehabilitation program from any and all liability for damage of any kind or character resulting from any injury or condition that I may suffer, or may result from such a rehabilitation program.

THIS FORM HAS BEEN EXPLAINED TO ME AND I SIGN IT VOLUNTARILY.

\_\_\_\_\_  
**PARTICIPANT SIGNATURE**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**EXCEL EMPLOYEE SIGNATURE**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**PARENT OR GUARDIAN SIGNATURE**

\_\_\_\_\_  
**DATE**

**CANCELLATION  
(Of Consent to Disclose Information)**

*I hereby void the consent given above.*

*Print Name of Patient:* \_\_\_\_\_

*Signature:* \_\_\_\_\_

*Date:* \_\_\_\_\_

*If you are signing as the patient’s representative:*

*Print Your Name:* \_\_\_\_\_

*Relationship:* \_\_\_\_\_

*Address for cancellation: Your cancellation will be effective, upon receipt, at the following address:*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_