BELLA
PHYSICAL THERAPY
Regain. Renew. Recover.

Bella Physical Therapy • 39-40 Broadway, Suite 4, 2nd Floor • Fair Lawn, NJ 07410
Phone: 201-791-0008 • Fax: 201-791-7111 • Email: bellaphysicaltherapy@gmail.com
www.bellaphysicaltherapy.com • Hours: Mon-Fri, 10 am to 8 pm • Closed Saturday and Sunday

HIPAA CONSENT

Our Notice of Privacy Practices brochure provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

TREATMENT CONSENT

By reading and signing this document, I, the undersigned patient (or legally authorized representative) consent to and authorize the performance of any treatments, examinations, medical services, and diagnostic procedures done by healthcare professionals Bella Physical Therapy PC.

Healthcare professionals cannot guarantee any specific result(s) of any examination, treatment, procedure or medical care. I release Bella Physical Therapy, PC from any liability for any accident or injury that is not directly caused by the negligence of employees of Bella Physical Therapy PC.

During the course of my care and treatment, I understand that various types of examinations, tests, diagnostic or treatment procedures ("procedures") may be necessary. These procedures may only be performed by physical therapists on staff. While routinely performed without incident, there may be material risks associated with these procedures. If I have any questions concerning these procedures, I will ask my therapist(s) to provide me with additional information.

I understand that the healthcare professionals involved in my care will rely on my documented medical history, as well as other information provided by me, my immediate family, or others having information about me, in determining whether to perform or recommend procedures. I agree to provide accurate and thorough information regarding my medical history and any conditions or events which may impact medical decision-making.

By signing this document, I certify that I have read and understand its contents and that information provided by me is accurate and complete (including insurance information and current eligibility for benefits).

APPOINTMENT CANCELATION POLICY

Bella Physical Therapy has a 24 hour cancelation policy. In the event you need to cancel your appointment, please feel free to call the office at (201)791-0008 with at least 24 hours' notice. If you do not give 24 hour notice for missed or canceled appointments you are subject to a cancelation fee.

Patient's Name:_____

_____ _____
Signature of Patient or Legally Authorized Representative Date