ROGUE
PHYSICAL THERAPY

PATIENT CONSENT

Patient Notification Policy
In compliance with the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule and Notice of Privacy Practices, Nathan Lewis, DPT will not disclose your protected health information ("PHI") without your explicit authorization, except as permitted by law for the purposes of payment, treatment and coordination of your medical care. Furthermore, Nathan Lewis, DPT will limit the use, disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. Therefore, Nathan Lewis, DPT will only disclose your appointment information, such as reminders or cancellations, on voice mail, text message or e-mail, unless you inform us otherwise. This notice refers to Nathan Lewis, DPT as "us" and "our," and to the patient/guardian as "I," "my," "you," "your," and "yourself." I, the undersigned, hereby authorize Nathan Lewis to disclose my appointment information by the following methods of communication and I assume all responsibility for ensuring that the methods of communication that I indicate below are secure, with password protection used where applicable. If you choose to have your PHI communicated to individuals other than yourself, please accurately complete the information below and sign the authorization. I further agree to be responsible for notifying Nathan Lewis, DPT if any of the foregoing change. I, the undersigned, hereby authorize Nathan Lewis, DPT to disclose my PHI to the person(s) named below.

Name _____ Relationship _____Phone #_____
Name _____ Relationship _____Phone #_____

Patient Signature: _____Date: _____

Consent for Care & Treatment
I fully understand and acknowledge that (a) the activities in which I will engage as part of the treatment provided by Nathan Lewis, DPT and the equipment I may use as a part of that treatment have inherent risks, dangers, and hazards and such exists in my use of any equipment and my participation in these activities; (b) my participation in such activities and/or use of such equipment may result in injury or illness including, but not limited to, bodily injury, disease, strains, fractures, partial and/or total paralysis, death or other ailments that, could cause serious disability. By my participation in these activities and for use of equipment, I hereby assume all risks and dangers and all responsibility for any losses and/or damages caused. I, on behalf of myself, my personal representatives and my heirs, hereby voluntarily agree to release, waive, discharge, hold harmless, defend, and indemnify Nathan Lewis, DPT from any and all claims, actions or losses for bodily injury, property damage, wrongful death, loss of services or otherwise which may arise out of my use of any equipment or participation in these activities. I specifically understand that I am releasing, discharging, and waiving any claims or actions that I may have presently or in the future for the negligent acts or other conduct by Nathan Lewis, DPT. I consent to and authorize Nathan Lewis, DPT to administer physical therapy treatment as an Oregon licensed physical therapist. I understand and am informed that, as in the practice of medicine, physical therapy may have some risks. I understand that I have the right to ask about these risks and have any questions about my conditions answered prior to treatment. I know it is up to me to inform the physical therapist about any health problems or allergies I have, as well as medications I am taking.

Patient Signature: _____ Date: _____

Financial Responsibility
I understand and am responsible for the agreed fee for service of $100 per 45 minute treatment or if using health insurance, I understand that I am ultimately responsible for fees charged by clinician, and agree to pay any balance not covered, or disallowed by insurance

I hereby authorize release of any personal information necessary to process my claim, including my diagnosis. I understand that this information may become a permanent part of my insurance records. I authorize payments of benefits directly to Nathan Lewis DPT, LLC.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

Patient Signature: _____ Date: _____