Steve Cuddy, MPT, PRC

Postural Restoration®/Manual Therapy/Custom Orthotics
2507 Sutherland Street
Austin, TX 78746
512.769.9081

Medically Informed Consent for Treatment

I voluntarily consent to physical therapy treatment and services deemed necessary by my physical therapist and/or physician. I am aware that the practice of physical therapy is not an exact science and I acknowledge that no guarantees have been made to me as to the results of these services with Steve Cuddy, MPT, PRC. I understand that it is the therapist's sincere intent to educate me on every process, from completing these intake forms to what I may expect at the time of my discharge from physical therapy. Therefore, if "hands on" manual therapy techniques and/or exercises that are being used to restore normal function are not fully understood or desired it is my responsibility to obtain a clearer understanding or what the therapist's objectives are or immediately refuse this aspect of treatment. If I feel pain and/or do not consent or feel comfortable physically or emotionally with any aspect of the treatment, it is also my responsibility to make this immediately clear to the therapist providing treatment.

***Payment at the time of service. Check or cash only, please.*

****Please read…Cancellation Policy: Because I often have a waiting list, 24-hour notification is required for all cancellations so that attempts can be made to fill your vacated spot on my schedule. Patients with cancellations of less than 24-hour notification will be charged $95. No Show appointments without prior notification will be charged the full amount of your visit (less supply charges (i.e. orthotics)).*

This consent shall be on-going for the treatment period.

I have read this form and fully understand and accept its terms and conditions:

Patient's name ____________________________________

Patient's signature _________________________________ Date _____________

Signature of guardian (if patient is under 18 years of age) _________________________

Signature of witness ________________________________

SUMMARY OF NOTICE OF PRIVACY PRACTICES
Our complete Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to help you obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training students.
Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will **not** use or disclose your health information without your written authorization.
Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:
- To family members or close friends who are involved in your health care;
-For purposes of public health and safety;
-To Government agencies for purposes of their audits, investigations & other oversight activities;
-To Government authorities to prevent child abuse or domestic violence;
-To the FDA to report product defects or incidents;
-To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
-When required by court orders, search warrants, subpoenas & as otherwise required by law.
Patient Rights. As our patient, you have the following rights:
-To have access to and/or a copy of your health information;
-To receive an accounting of certain disclosures we have made of your health information;
-To request restrictions as to how your health information is used or disclosed;
-To request that we communicate with you in confidence;
-To request that we amend your health information;
-To receive notices of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to our complete Notice of Privacy Practices for the person or persons whom you may contact.

Acknowledgement of Receipt of Notice from Steve Cuddy Physical Therapy

I hereby acknowledge that I have reviewed the Summary of this medical practice's Notice of Privacy Practices and am aware that I may view a more detailed Notice of Privacy Practices.

Signed: ________________________________ **Date:** ____________________________

Print Name: ____________________________

If not signed by the patient, please indicate Relationship:
__ parent or guardian of minor patient
__ guardian or conservator of an incompetent patient
__ beneficiary or personal representative of deceased patient