

# OUTPATIENT THERAPY SERVICES

## Letter of Agreement

Client Name: \_\_\_\_\_ ID No: \_\_\_\_\_

### Patient Rights

I have read, or have had read to me, and received a copy of the Patient's Rights and Responsibilities and Grievance Procedure Statement. I understand my rights and responsibilities and grievance procedure as stated.

### Consent for Treatment

I hereby authorize the Peter B. Lewis Aquatics & Therapy Center and/or Menorah Park Outpatient Therapy Clinics and its agents to provide the above named patient with the care, treatments, and procedures ordered by his/her physician and as requested by this patient or his/her guardian. The risks and possible adverse consequences of treatment will be explained prior to initiation of treatment and I have the right to refuse said treatment.

### Authorization for Release of Information

I hereby authorize the Peter B. Lewis Aquatic & Therapy Center and/or Menorah Park Outpatient Therapy Clinics to release such information as may be necessary for the coordination or continuation of my care to other service providers and to the third party payor (including Fiscal Intermediary) as required to receive payment. I also consent to the release of information from prior health records to the Peter B. Lewis Aquatics & Therapy Center and/or Menorah Park Outpatient Therapy Clinics as needed by its agent.

This medical information may include the medical record as well as information concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological conditions and AIDS or AIDS related conditions. The review of the records is also authorized.

### Emergency

I understand that it is the policy of Peter B. Lewis Aquatics & Therapy Center and/or Menorah Park Outpatient Therapy Clinics that in case of an emergency, 911 will be notified immediately and CPR will be initiated by staff trained in these basic techniques.

Attendance: \_\_\_\_\_ Client Initials: \_\_\_\_\_

\_\_\_\_\_ *In order to show progress toward therapy goals, a client MUST attend scheduled sessions. A client who misses three (3) consecutive or more than four (4) visits will be discharged from skilled therapy.*

\_\_\_\_\_ *CO-PAY MUST be paid at time therapy is rendered.*

