CONSENT FOR CARE AND TREATMENT:

I hereby agree and give my consent to Engage PT, OT, SLP PLLC to furnish appropriate rehabilitative care and treatment, as considered necessary and in the best interest in order to attend to the physical condition. I understand that the benefits and risks to all interventions will be explained and that the patient holds the final judgment in such matters.

RESPONSIBILITY FOR PAYMENT:

All co-payments and self –pay services are due at the time of service. I acknowledge that in consideration of the services provided to me by Engage, I am financially responsible for payment of my bill. I acknowledge that it is my responsibility to provide Engage with my current insurance information and to familiarize myself with my insurance plan and its policies. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan. My health insurance plan may provide that all or a portion of the charges and balance will remain my personal responsibility, such as my deductible, co-payment, co-insurance or charges not covered or denied by my health insurance, Medicare, or other programs for which I am eligible. I agree to pay any such amounts which are my responsibility. I understand that Engage will bill my personal insurance carrier as a courtesy, but that I am ultimately responsible for any amounts owed. If formal collection procedures become necessary, I am responsible for any additional costs incurred as a result of such collection procedures. If I pay any amount with a check, I hereby authorize Engage to use the information from the check to process a one-time Electronic Funds Transfer (EFT/ACH) or a draft drawn from my account. I understand that if my payment is processed as an EFT, funds may be withdrawn from my account as soon as the same day and I will not receive my check back from my financial institution. Please note that refusal to sign this form does not change responsibility for payment in any way.

ACCESS TO AND RELEASE OF HEALTH INFORMATION:

I understand that Engage may document medical and other information related to my treatment in electronic and other forms and that such information will be used in the course of my treatment, for payment purposes and to support those who are caring for me. I authorize my clinician(s) and Engage's administrative staff to contact other healthcare professionals that may have information related to my prior and current health conditions and treatment. I acknowledge that I have received Engage's Notice of Privacy Practices and that it outlines how my health information may be used and disclosed and how I may gain access to and control my health information. I acknowledge that I have received Engage's Notice of Privacy Practices and that it outlines how my health information may be used and disclosed and how I may gain access to and control my health information. By my signature below, I certify that I have read, understand, and fully agree to each of the statements in this document and sign below freely and voluntarily.

AUTHORIZATION TO PAY:

I hereby authorize insurance payment directly to Engage PT, OT, SLP at 3175 East Genesee Street Suite 5 Syracuse NY 13224 for medical services rendered. I understand that I am financially responsible for the charges not covered by my insurance. In the event of default, I

promise to pay collection costs and reasonable fees as may be required to obtain collection of this account.

ATTENDANCE AGREEMENT:
Due to the nature of therapy, your progress and full recovery are dependent on both our experienced therapists, and your active participation and commitment to your appointments. If you need to cancel your appointment, please contact Engage at least one day prior to your appointment. If you call to cancel your appointment on the same day as your appointment or if you do not show, a $25.00 cancellation fee will be assessed.

TELEHEALTH:
This means that through an interactive video connection, I will be able to consult with the above named provider about my health and wellness concerns. I understand there are potential risks with this technology: The video connection may not work or it may stop working during the consultation. The video picture or information transmitted may not be clear enough to be useful for the consultation. The benefits of a telehealth consultation are: I do not need to travel to the consult location. I have access to a specialist through this consultation. I also understand other individuals may need to use the Heno telehealth platform and that they will take reasonable steps to maintain confidentiality of the information obtained. I have read this document and understand the risk and benefits of the telehealth consultation and have had my questions regarding the procedure explained and I hereby consent to participate in telehealth sessions under the conditions described in this document.

Patient's FULL NAME:

Signature of PATIENT or LEGAL GUARDIAN:

Date: