

CONSENT FOR HEALTH SERVICES/TREATMENT AND PRODUCTS

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Our Mission Statement

•Three Rivers Therapy Services’ mission is to provide uncompromising, quality care to the residents of Coshocton and the surrounding areas.

•As a company, Three Rivers Therapy is committed to providing an atmosphere, which promotes the development of its employee’ skills and supports their professional growth.

•All activities of Three Rivers Therapy shall reflect recognition of the rights and dignity of all employees, patients, families, students, referral sources, and community members.

**CORE VALUES**: Honesty, Integrity, Passion, Trust.

CONSENT FOR CARE – I understand that by signing this agreement, I authorize Three Rivers Therapy Services, LLC to provide health services, treatments and products as prescribed by my physician. I understand I am required to remain under physician care during the course of treatment. I understand the therapy I am to receive and I understand any possible risks involved.

PATIENT PRIVACY NOTICE - I understand and have reviewed Three Rivers Therapy Services, LLC “Notice of Privacy Practices”, which discloses ways my personal health information may be used or disclosed and outlines my rights with respect to such information.

RELEASE OF INFORMATION – I authorize Three Rivers Therapy Services, LLC to release my health information to referring physicians/agencies/providers involved in my care. I understand that all information shared will remain confidential.

I authorized the disclosure of all or part of my medical records from any hospital, nursing home, physician office or other health care facility to Three Rivers Therapy Services, LLC .

Emergency Contact – Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I fully understand and accept the terms of this “Consent for Health Services” and have carefully read my “Patient’s Rights and Responsibilities”.

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Signature of Patient or Legal Guardian Date

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Other signature - Relationship to Patient

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Signature of Witness Date

05/2010