DEFY
THERAPY & WELLNESS

15807 Biscayne Blvd #113, N. Miami Beach, FL 33160, T .786.955.6912, F.786.955.6956
Email: info@defytherapyandwellness.com,
defytherapyandwellness.com

PATIENT AUTHORIZATION FORM

THIS FORM IS TO CONFIRM YOUR AUTHORIZATION TO USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) AND GIVES APPROVAL TO BE TREATED FOR YOUR CONDITION

1. INDIVIDUAL PATIENT (OR PERSONAL REPRESENTATIVE) CONFIRMING AUTHORIZATION:

I give my voluntary authorization to use or disclose my PHI as described in SECTION 2 below.

PATIENT NAME:_____ DOB:_____
ADDRESS:_____

PHONE:_____ CELL:_____

EMAIL:_____

2. THE USE AND/OR DISCLOSURE AUTHORIZED:

2A. DESCRIBE THE PHI YOU ARE AUTHORIZING TO BE USED OR DISCLOSED:

☑ PHYSICAL THERAPY ☑ OCCUPATIONAL THERAPY ☑ SPEECH THERAPY
☑ RECORDS (FILES) ☑ THERAPY NOTES □ OTHER: _____

2B. NAME THE INDIVIDUAL AND/OR ORGANIZATION OTHER THAN YOUR REFERRING PHYSICIAN AND YOUR INSURANCE COMPANY THAT YOU ARE ALSO AUTHORIZING TO RECEIVE AND USE YOUR PHI:

(YOU ARE AUTHORIZING DEFY THERAPY & WELLNESS TO USE OR DISCLOSE THE PHI DESCRIBED ABOVE)

DOCTOR/ORGANIZATION/INDIVIDUAL:_____

INSURANCE(S):_____

AGENT:_____

2C. DESCRIBE THE PURPOSE FOR WHICH YOU ARE AUTHORIZING YOUR PHI TO BE USED AND/OR DISCLOSED:

☑ MEDICAL RECORDS ☑ BILLING PURPOSES ☑ OTHER:_____

3. VOLUNTARY ADMISSION: I VOLUNTARILY CONSENT TO MY ADMISSION AT DEFY THERAPY & WELLNESS

☑ YES □ OTHER:_____

YOU HAVE A RIGHT TO A COPY OF THIS FORM AFTER YOU SIGN IT.

DEFY
THERAPY & WELLNESS

15807 Biscayne Blvd #113, N. Miami Beach, FL 33160, T .786.955.6912, F.786.955.6956
Email: info@defytherapyandwellness.com,
defytherapyandwellness.com

PATIENT AUTHORIZATION FORM

THIS FORM IS TO CONFIRM YOUR AUTHORIZATION TO USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) AND GIVES APPROVAL TO BE TREATED FOR YOUR CONDITION

4. CONSENT TO TREATMENT: I AUTHORIZE DEFY THERAPY & WELLNESS TO PROVIDE OCCUPATIONAL/PHYSICAL/SPEECH THERAPY AND/OR REHABILITATION SERVICES AS PRESCRIBED BY MY PRIMARY CARE PHYSICIAN OR BY ANY OTHER PHYSICIAN WHO MAY BE TREATING ME, INCLUDING ALL DIAGNOSTIC AND THERAPEUTIC TREATMENTS THAT MAY BE CONSIDERED NECESSARY AND IN THE JUDGEMENT OF THE PHYSICIAN AND/OR THERAPIST AFTER THE INITIAL EVALUATION. I HEREBY RELEASE DEFY THERAPY & WELLNESS FROM ALL LIABILITY INCURRED AS A RESULT OF MEDICAL TREATMENTS PROVIDED BY THE EMPLOYEES OF THE AGENCY.

☑ YES ☐ OTHER:_____

5. EMERGENCY CONTACT: I UNDERSTAND THAT DURING THE COURSE OF MY PROGRAMMED SESSIONS, THE NEED FOR EMERGENCY TREATMENT AND/OR TRANSFER TO A HOSPITAL MAY BECOME NECESSARY. I UNDERSTAND THAT DEFY THERAPY & WELLNESS DOES NOT PROVIDE EMERGENCY MEDICAL CARE. THEREFORE, SHOULD THE NEED FOR SUCH TREATMENT AND/OR TRANSFER BE DEEMED NECESSARY BY MY THERAPIST, DEFY THERAPY & WELLNESS STAFF WILL CALL 911. I ASSUME SOLE RESPONSIBILITY FOR ALL CHARGES THAT MAY ARISE. I UNDERSTAND THAT MY EMERGENCY CONTACT WILL BE INFORMED IF SUCH EVENTS TAKE PLACE.

☑ YES ☐ OTHER:_____

6. CHANGING AUTHORIZATION: I UNDERSTAND THAT I MAKE REVOKE THIS AUTHORIZATION AT ANY TIME BY GIVEN A WRITTEN NOTICE TO KELSEY ZAMOYSKI, PRIVACY OFFICER AT DEFY THERAPY & WELLNESS. HOWEVER, I UNDERSTAND THAT I MAY NOT REVOKE THIS AUTHORIZATION FOR ANY ACTIONS TAKEN BEFORE RECEIPT OF MY NOTICE TO REVOKE IT. IN ADDITION, I UNDERSTAND THAT IF I AM GIVING THIS AUTHORIZATION AS A CONDITION TO OBTAIN INSURANCE COVERAGE, AND I REVOKE THIS AUTHORIZATION, THE INSURANCE COMPANY HAS A RIGHT TO CONTEST MY CLAIMS UNDER THE INSURANCE POLICY.

7. SIGNING THIS AUTHORIZATION IS NOT A CONDITION OF TREATMENT: (THIS SECTION 8 IS OVERRULED IF THE PATIENT AGREES TO SECTIONS 3 & 4): I UNDERSTAND THAT SIGNING THIS AUTHORIZATION TO DEFY THERAPY & WELLNESS UNDER MOST CIRCUMSTANCES, IS NOT A CONDITION OF TREATMENT, ENROLLMENT, ELIGIBILITY, OR PAYMENT, FOR BENEFITS. HOWEVER, I UNDERSTAND THAT SIGNING AN AUTHORIZATION THAT PERMITS THE USE AND/OR DISCLOSURE OF MY PHI FOR RESEARCH PURPOSES MAY BE A CONDITION OF MY TREATMENT IF I AM UNDERGOING RESEARCH-RELATED TREATMENT. ALSO, I MAY BE REQUIRED TO SIGN AN AUTHORIZATION IF MY TREATMENT IS PROVIDED SOLELY FOR THE PURPOSE OF CREATING PHI FOR DISCLOSURE TO A THIRD PARTY; AND UNDER SOME CIRCUMSTANCES, A HEALTH PLAN MAY CONDITION MY ENROLLMENT IN A HEALTH PLAN OR ELIGIBILITY FOR BENEFITS ON ME PROVIDED AN AUTHORIZATION PERMITTING THE HEALTH PLAN TO MAKE ENROLLMENT AND ELIGIBILITY DETERMINATIONS.

YOU HAVE A RIGHT TO A COPY OF THIS FORM AFTER YOU SIGN IT.

DEFY
THERAPY & WELLNESS

15807 Biscayne Blvd #113, N. Miami Beach, FL 33160, T .786.955.6912, F.786.955.6956
Email: info@defytherapyandwellness.com,
defytherapyandwellness.com

PATIENT AUTHORIZATION FORM

THIS FORM IS TO CONFIRM YOUR AUTHORIZATION TO USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) AND GIVES APPROVAL TO BE TREATED FOR YOUR CONDITION

8. INDIVIDUAL PATIENT'S SIGNATURE: I HAVE HAD THE CHANCE TO READ AND THINK ABOUT THE CONTENT OF THIS AUTHORIZATION FORM AND I AGREE WITH ALL STATEMENTS MADE IN THIS FORM. I UNDERSTAND THAT, BY SIGNING THIS FORM, I AM CONFIRMING MY AUTHORIZATION FOR USE/AND DISCLOSURE OF THE PHI DESCRIBED IN THIS FORM WITH DEFY THERAPY & WELLNESS AND EACH OF THE ORGANIZATIONS NAMED IN THIS FORM.

_____ DATE: _____/_____/_____
PATIENT'S SIGNATURE

IF AUTHORIZATION IS SIGNED BY A PERSON OTHER THAN THE PATIENT (PATIENT REPRESENTATIVE):

_____ _____
PATIENT'S REPRESENTATIVE'S NAME (PRINT) RELATIONSHIP TO PATIENT

_____ DATE: _____/_____/_____
PATIENT'S REPRESENATIVE'S SIGNATURE

_____ DATE: _____/_____/_____
EMPLOYEE / WITNESS SIGNATURE

YOU HAVE A RIGHT TO A COPY OF THIS FORM AFTER YOU SIGN IT.