333 Earle Ovington Blvd, LL
Uniondale, NY 11553
516.888.0123 | 516.324.4034
info@ptomni.com | ptomni.com

Name of patient: _____ Date: _____

Patient Agreement

Thank you for choosing Omni Physical Therapy Services for your physical Therapy needs.

Consent for Treatment: I authorize the staff of Omni Physical Therapy Services(OmniPT), their employees and consultants to undertake such evaluations treatment, diagnostic procedures and medical procedures, which in their judgment may become necessary while receiving care at OmniPT. I understand that I will be involved and engaged in my care and treatment; and that I have a right to a full explanation of any treatment or procedures utilized. I am aware the practice of medicine is not an exact science and I understand no guarantees have been made to me regarding the results of treatment or examinations. As a patient of OmniPT I understand that individuals being trained in health care may participate in my care. I understand that if I require specialized, emergency care, or care which is out of the scope of practice for OmniPT I will be referred to the appropriate facility and/or providers. I understand that a person listed as my emergency contact will be notified if considered necessary by the professional staff at OmniPT.

Financial Guarantee

I understand that I am fully responsible for all charges regardless of my insurance benefits. I authorize the use of the signature below on all insurance submissions. I may elect to pay any bill in full in lieu of submitting a claim for insurance reimbursement and understand that I am responsible for notifying OmniPT prior to billing if I elect to do so.

I understand that I am authorizing Omni Physical Therapy Services to bill my insurance by providing the insurance details, and that I will be responsible for any copay, coinsurance or deductible at the time of service for the services provided to me/my dependent. I hereby authorize my insurance company to distribute the payment of my coverage directly to OmniPT.

If OmniPT bills insurance, the billing charges will be at the actual or customary charges and not at any discounted amount.

If and when the insurance company makes a payment to me it is my responsibility to hand over the full payment to Omni Physical Therapy minus any amount paid prior personally.

I hereby give consent to Omni Physical Therapy Services to take any necessary steps to assure that the payments for services are made in a timely fashion.

I understand that I must provide OmniPT with accurate information on my insurance status at time of service if I wish to have OmniPT bill my insurance on my behalf

Consent to Treat a Minor

I, As a guardian/parent of a minor, do hereby agree and consent, my dependent child (Name) :
is to be treated by the staff of Omni Physical Therapy for physical therapy evaluation, treatment and procedures. I further agree and understand that I have been advised to remain with the minor during any such treatment and other procedures, and waive any claim I may have resulting from failure to do so.

Name: _____ Signature:_____
(Patient/Parent If Minor) (Patient/Parent If Minor)
Date: _____ Address:_____
SS# :_____ Drivers License No: _____
State Issued: _____ Date Issued: _____ Date of Expiry: _____