Notice of Advice for Patient's Requesting Physical Therapy Treatment under New York's Direct Access Law

Thank you for choosing Kulp Physical Therapy and Massage as your physical therapy provider.

You have decided to utilize our services under New York's "direct access to Physical therapy" law. Under this law, you may be treated by a physical therapist without a prescription or referral. You may be evaluated and/or treated by a licensed physical therapist for **up to 10 visits or 30 days, whichever comes first**. Please note that treatment under New York's Direct Access Law is not applicable to Worker's Compensation or Medicare patients. Please take note; If you are seeking care and have an insurance plan that states physical therapy must be ordered/prescribed by a physician to be covered by your policy then accessing PT using this form makes you ineligible for coverage and you waive your right to have your insurance billed.

We are required to inform you that this treatment may not be paid by your insurance carrier if you have not obtained a prescription/referral for physical therapy, if required by your insurance, from a physician, dentist, podiatrist or nurse practitioner licensed to practice in New York State. We are also required to inform you that this treatment may be paid by your insurance carrier if you were to have obtained a valid prescription/referral, if a prescription/referral is required by your insurance carrier.

We will bill your insurance carrier for services rendered but in the event they do not pay due to a missing prescription or referral, you will be responsible for the entire unpaid balance.

I have read this form and acknowledge that I am about to obtain physical therapy treatment for myself, or my minor child, under New York's Direct Access law. I understand that my insurance carrier may not pay for these services since I have not obtained a prescription and/or referral from a NYS licensed physician, dentist, podiatrist or nurse practitioner. I understand and accept that this will make me personally liable for today's charges as well as future treatment under the Direct Access Law.

Date Treatment will begin: _____/_____/_____ I would like a copy for my records _____ yes _____no

_____ _____

Name of Patient- Please print (If a minor) Name of Parent/Guardian- Please print

_____

Address of Patient

_____ _____/_____/_____

Signature of Patient or Guardian **Date**

Specific Symptom(s) or Complaint:_____

If an injury please specifically indicate; the how, where and when. _____

Have you consulted your doctor? ____Yes ____ No If yes whom? _____

_____ _____/_____/_____ _____/_____/_____

Therapist Signature **Date** ***Expiration Date**

__ Leah Valvo, MSPT ***for treatment to continue beyond this date you must obtain a Doctor's prescription***

__ Douglas L. Kulp, PT, CMTPT

DX:_____ ____left _____right _____ bilateral