

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

Thank you for choosing Excellence in Physical Therapy as your physical therapy provider.

You have decided to utilize our services under New York's "direct access to physical therapy" law, which is effective November 23, 2006. 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, Medicare or No-Fault coverage. If you are seeking care under Worker's Compensation, Medicare or No-Fault coverage, physical therapy **MUST** be prescribed by your physician to be covered.

We are required to inform you that this treatment **may not** be paid by your insurance carrier if you have not obtained a prescription for physical therapy, and a 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 and referral, if a referral is required by your insurance carrier.

We require co-payment or co-insurance payments to be made at time of treatment. We will bill your carrier for the balance 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 New York State 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.

Name of Insurance Carrier: _____

Insurance ID#: _____

Date Treatment will begin: ____ / ____ / ____

Name of Patient – please print

Address of Patient

Name of Guardian – please print

Signature of Patient or Guardian

____ / ____ / ____
Date

Therapist Name

675 Atlantic Avenue
Rochester, NY 14609

Therapist Signature

____ / ____ / ____
Date