NOTICE OF ADVICE – DIRECT ACCESS LAW

Pursuant to Chapter 298 of the Laws of 2006, New York State law authorizes eligible physical therapists (with a minimum of three years of practical experience or the equivalent) to treat patients without a referral from a physician, dentist, podiatrist or nurse practitioner ("Direct Access Law"). However, the Direct Access Law does not apply to patients who are covered under workers' compensation insurance, no-fault insurance, Medicare or to patients who have pending liability cases.

In accordance with the Direct Access Law, I attest that:

- **I understand that my treatment may not be covered by my health care plan or insurer without a referral from a physician, dentist, podiatrist, or nurse practitioner and that my treatment may be a covered expense if rendered with a referral.**
- **I understand that I am responsible for contacting my health care plan or insurer to determine whether my health care plan or insurer covers my treatment without a referral from a physician, dentist, podiatrist, or nurse practitioner.**
- **I understand that treatment without a referral is limited to ten (10) visits or thirty (30) days, whichever occurs first.**
- **Treatment will begin on _____.**
  Date
- **My treatment is not related to a no-fault injury or a workers' compensation covered injury, that there is no pending liability case related to my condition, and I am not insured through Medicare.**
- **I understand that I am fully responsible for any and all costs associated with the direct access treatment session(s) that are due and owing Professional Physical Therapy and not otherwise covered by my health care plan or insurer.**

I attest that I have read and understand this Notice of Advice regarding New York State's Direct Access Law and I consent to receive physical therapy treatment from Professional Physical Therapy without a referral from a physician, dentist, podiatrist, or nurse practitioner.

_____ _____ _____
Patient's Name **Signature of Patient or Legal Guardian** **Date**

_____
Patient's Address

_____ _____ _____
Treating Physical Therapist's Name **Treating Physical Therapist's Signature** **Date**

_____
Treating Physical Therapist's Address

_____
Legal Guardian's Name

For Office Use Only:

Received By: _____ _____ _____
Print Name **Signature** **Date**