

I, \_\_\_\_\_, have read a copy of the privacy practices. (This document is available at our front desk).

\_\_\_\_\_ (initial) **CANCELLATION POLICY**

If the patient cannot adhere to a scheduled appointment, it is the patient's responsibility to call the office to cancel within 24 hours of the scheduled appointment. A fee of \$65.00 will be charged for the first appointment canceled less than 24 hours and \$135.00 for each subsequent appointment. If you sign up for a class and do not cancel with 24 hours of your class, you will be charged \$25.00 per class.

\_\_\_\_\_ (initial) **RELEASE OF MEDICAL INFORMATION**

I do / I do not (circle one) authorize Hands on Physical Therapy to release medical information to my spouse, parent or guardian.

\_\_\_\_\_ (Initial) **Contact Permission**

In the event that Hands on Physical Therapy needs to contact you (patient) regarding appointments, billing, treatment or any other reason, it is permissible to:

- Leave a message on the answering machine. Phone # you wish us to call \_\_\_\_\_
- Speak with a spouse/significant other.
- Speak with other family members.

\_\_\_\_\_ (initial) **CONSENT TO TREATMENT**

I consent to the performance of examinations, and rendering of treatment by the medical provider and their designated medical office staff as is deemed necessary in the medical provider's judgment.

\_\_\_\_\_ (initial) **AUTHORIZATION / ASSIGNMENT / FINANCIAL RESPONSIBILITY**

I authorize the release of any medical information necessary to process an insurance claim on my behalf. I understand that I am financially responsible for all charges and that I am responsible for obtaining any referrals required by my insurance carrier. I request that my medical insurance/automobile insurance carrier make payment directly to Hands on Physical Therapy for services rendered to me. As a courtesy, my charges will be filed with my insurance carrier; however, I will be billed if the claims are denied or are not paid in a timely manner. Should my account become a collection problem, additional charges may be incurred.

**My signature below indicates that I have read and am in agreement with all statements that I have initialed above.**

\_\_\_\_\_

Signature of Patient (or guardian)

\_\_\_\_\_

Date