Dr. Physio
THERAPY & WELLNESS

LOCATIONS
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PATIENT INFORMATION CONSENT FORM

Consent to Physical, Occupational, Speech Therapy Evaluation and Treatment

I hereby consent to the evaluation and treatment of my condition by a licensed therapist hired by Dr. Physio Therapy & Wellness (DPTW). The therapist will explain the nature and purposes of these procedures, evaluation, and course of treatment. The therapist will inform me of expected benefits and complications, and any discomforts, and risks that may arise, as well as alternatives to the proposed treatment and the risk and consequences of no treatment.

Assignment of Benefits and Insurance Proceeds

I authorize payment of medical benefits to Dr. Physio Therapy & Wellness for services rendered. Dr. Physio Therapy & Wellness will make reasonable efforts to collect insurance proceeds by completing insurance forms and sending the forms to the insurance company. Completion of such forms and/or the acceptance of assignment of insurance benefits does not relieve the undersigned of the obligation to pay the amount owed for therapy.

Patient Information Consent Form (HIPAA)

I have read and fully understand Dr. Physio Therapy & Wellness Notice of Information Practices. I understand that Dr. Physio Therapy & Wellness may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of service provided, and any administrative operations related to treatment or payment. I understand that I have the right to request restrictions, in writing, regarding how my personal health information is used and disclosed for treatment, payment, and administrative operations. I also understand that Dr. Physio Therapy & Wellness will consider requests for restrictions on a case by case basis, but is not required to oblige to such requests.
I hereby consent to the use and disclosure of my personal health information for purposes as noted in Dr. Physio Therapy & Wellness Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time, at which point Dr. Physio Therapy & Wellness has 30 days to respond to my request.

Release of Information

I hereby authorize the release of information necessary to file claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

Designated Individuals Authorization

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties will be verified by photo ID before the release of any information. If none, please print “none” below.

Authorized Designees:

Name:_____ **Relationship**:_____

I have read and understand the above consents, assignment of benefits, release of information, and designated individuals authorization above.

LATE CANCEL / NO SHOW POLICY

Please call our office if you cannot come to an appointment already scheduled. If you do not call at least 24 hours (during business hours) prior to your appointment time, there will be a $25 late cancellation fee. Failure to call or show for an appointment will result in a $50 no-show fee.

_____	_____	_____ /_____ /_____
Print Patient Name	**Signature of Patient/Guardian**	**Date**