Consent For Treatment

I hereby give my consent for medical treatment of my physical condition. I authorize the release of any medical information needed to process my claim. I understand that I am responsible to inform the office of any changes that occur with regard to my insurance policy. If I choose to file a claim through my insurance, I authorize release of payment directly to Elevate Physical Therapy regardless of whether benefits are deemed to be in-network or out-of-network. Should I default on my financial responsibility and monetary collection is necessary, I will be responsible for collection costs that are incurred.

Patient/Parent/Guardian Signature: ____ Date: ______________

Patient/Parent/Guardian Name (Please Print): ____

Receipt of Policies

I acknowledge that I have received the packet of patient policies which includes the following: HIPAA Notice of Privacy Practices, Attendance Policy, Financial Policy, and Financial Responsibilities. I understand that I may ask questions about these policies at any time.

Patient/Parent/Guardian Signature: ____ Date: ______________

Contact Information

1) Please indicate any family members we may speak with regarding your care including but not limited to diagnosis, treatment plan, or prognosis.

____ ____

____ ____

2) May we leave a message on your answering machine/cell phone? Yes No
3) How would you like to receive appointment reminders? Text Email

NOTE: By choosing one of the above options, I authorize Elevate Physical Therapy or entities acting on behalf of Elevate Physical Therapy (e.g. debt collection agency) to deliver messages to me using an automated dialing system and/or artificial pre-recorded voice in accordance with the FCC's Telephone Consumer Protection Act. I understand that by choosing "No" I have opted not to receive messages using an automated dialing system or pre-recorded voice.

Child/Adolescent Protection Policy (For patients under 18 years of age)

It is the policy of Elevate Physical Therapy to release minors only to the care of the following individuals after completion of their physical therapy visit.

____ ____

____ ____

Patient/Parent/Guardian Signature: ____ Date: ______________