Physical Therapy Consent Form

Patient's Name: _________________________________

_____ **Consent**: I consent to and authorize Provision Physical Therapy (including students in training) to administer physical therapy treatment under the direction and supervision of the physical therapist. I understand and am informed that, as in the practice of medicine, physical therapy may have some risks. I understand that I have the right to ask about these risks and have any questions about my conditions answered prior to treatment. I know it is up to me to inform the physical therapist/staff about any health problems or allergies I have, as well as medications I am taking.

____ **Minor Patients**: The parent or guardian accompanying a minor is responsible for payment of services. Unaccompanied minors (under 18) will be denied non-emergency treatment, unless the parent or guardian has signed patient and financial responsibility forms.

_____ **Release of Information**: Provision Physical Therapy releases patient health care information for purposes of treatment or payment, or to other health care organizations, as explained in our HIPAA Notice of Privacy Practice. I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.

_____ **Payment Guarantee**: I agree to pay Provision Physical Therapy for the services provided to me. I understand my benefits and my responsibility for all account balances. I understand that no contract, guarantee, warranty, or promise concerning the results of the physical therapy services is made.

_____ **Collections**: If your account becomes delinquent, collection proceedings will occur and you will be 100% liable for any collection fees, attorney and court costs incurred by Provision Physical Therapy to collect said fees from the Responsible Party.

_____ **No Show/Cancel**: Cancellations with less than 24 hrs notice will result in a $30.00 fee.

The undersigned patient or Responsible Party acknowledges that he/she has read and agrees to the information printed above.

Patient/Responsible Party Signature:________________________ Date: __________________