**Patient Consent Form**

Patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent to treat:**

The patient has the right to informed participation in decisions involving his/her healthcare. This shall be based on clear concise explanation of his/her condition and of all proposed treatment procedures. All possible risks and/or side effects, as well as the probability of success with such procedures shall be disclosed to the patient by his/her physical therapist. The patient shall not be subjected to any procedure without his/her consent or consent of his/her legally authorized representative.

**Treatment of minors:**

I, as parent/guardian of a minor receiving treatment at ***Conifer Physical Therapy***, do hereby agree and understand that I have been advised to remain on the premises during any such treatment and waive any claim I may have resulting from failure to do so.

**Liability:**

I know and agree that ***Conifer Physical Therapy*** is not responsible for loss and/or damage to personal valuables.

**Authorization of Payment:**

I hereby assign all insurance benefits directly to ***Conifer Physical Therapy*** and also authorize release of any medical records necessary to facilitate my treatment, to process medical claims and/or as otherwise permitted or required in the **Notice of Privacy Practices**. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.

**Financial Policy:**

We will gladly discuss your proposed treatment plan and discuss any questions relating to your insurance coverage. You must realize, however, that you insurance is a contract between you and your insurance company. We must emphasize that as your provider, our relationship is with you and not your insurance company. While filing of insurance claims is a courtesy we extend to our patients, there is no guarantee of payment.

**Note:** You should contact your insurance company if you have any concerns about your coverage. **All charges are ultimately your responsibility from the date of service rendered.**

Payment of co-pays or co-insurance amounts are required at the time of your visit. If we are informed that your insurance deductible has not been met, we may ask that you make a payment at each visit until the deductible amount is satisfied.

**Cancellation Policy:**

Please be on time for your appointments so that you may be given the full benefit of your scheduled treatment. Late arrivals of greater than 10 minutes may result in a shortened treatment session or cancellation. **There is a $60 charge for a cancellation without 24 hours’ notice.** Please be aware that other people are waiting to get on the schedule and when you cancel at the last minute it effects not only your treatment, but also the therapist and the person waiting for an appointment. Attending you scheduled appointments is also crucial to successful treatment and recovery from your injury or illness.

**Notice of Privacy Practices:**

A copy of the **Notice of Privacy Practices** is available in the front waiting area and a hard copy may be obtained upon request. I understand that ***Conifer Physical Therapy*** may use or disclose my personal health information (PHI) for the purpose of carrying out treatment and obtaining payment. I understand that I have the right to restrict how my PHI is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand I have the right to revoke this consent by notifying the practice in writing.

By signing below, I consent to rehabilitation and related services at ***Conifer Physical Therapy***.

By signing below, I hereby consent to the use and disclosure of my PHI as noted in Conifer Physical Therapy’s **Notice of Privacy Practices.**

I have read, understand and agree to the above information and policies.

Patient / Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_