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# Policies & Consent for Treatment

Please initial after each statement, then sign & date at the bottom of the page.

## Informed Consent for Treatment

I hereby give permission for physical therapy treatment to be given to myself/my dependent. I can receive information regarding my condition and the intended treatments and ask questions regarding my care. I understand that I may refuse treatment at any time, although it may result in less than optimal outcomes or even a worsening in my condition.

*Initials:*_____

## Consent to Release and Obtain Medical Information

I will allow Choice PT to release demographic and medical information to my referring healthcare provider, my insurance company, attorney, or other services related to my care and reimbursement for services rendered. I also give permission for Choice PT to request and receive medical records including but not limited to doctor notes, test results, and imaging studies, as they pertain to my condition and treatment.

*Initials:*_____

## Attendance Policy

In the event that I cannot keep a scheduled appointment with Choice PT, I agree to give notice at least 24 hours or one full business day prior to the appointment time. If I am not present for an appointment or fail to give appropriate notice, I agree to pay without dispute a $30 fee for each missed appointment. I understand that failure to comply with the therapist's recommended frequency and duration of treatment may result in poor outcomes and/or discharge by the facility.

*Initials:*_____

## Payment for Services Rendered / Authorization for Payment of Benefits

I understand that I am responsible for paying all insurance copayments, coinsurances, and deductibles, which are due at time of service. I will allow Choice PT to bill my insurance and be reimbursed accordingly. I understand that insurance pre-authorization and billing is done as a courtesy to me, but insurance reimbursement cannot be guaranteed. In the event that my insurance company does not pay or later takes back payment, I agree to pay for all visits affected. I am ultimately responsible for the cost of all services rendered and I agree to pay any balance as it is billed to me.

*Initials:*_____

## Collections Referral and Associated Fees

In the event that my account becomes delinquent, I agree to pay all costs of collections including attorney fees, collection fees, and contingent fees to collection agencies up to 40%. Such contingency fees will be added and collected by the collection agency immediately upon referral of my account to the collection agency.

*Initials:*_____

I certify that I understand all the above statements and agree to abide by these policies:

_____ _____

Signature Date