Patient Name:_____

Consent for Treatment

I hereby authorize Advanced Care Physical Therapy through its appropriate therapy personnel, to perform an evaluation and treatment procedures deemed necessary by the therapist, on me or the above-named patient if different than myself.

Authorization to Release Information

I hereby authorize Advanced Care Physical Therapy to release appropriate agencies, any information acquired during the course of my, or the above-named patient's evaluation and treatment, necessary to process claims and pay Advanced Care Physical Therapy directly for professional services rendered.

Acknowledgement of Receipt of Privacy Notice (HIPAA)

I acknowledge that I received, or was offered, or can request at any time the Notice of Privacy Practices for Advanced Care Physical Therapy.

Cancellation/No-Show Policy

I understand that 24 hours' notice is required for cancellation of an appointment except in the event of emergency situations. If I fail to cancel three or more appointments without 24 hours' notice and /or do not show up for three or more appointments, Advanced Care Physical Therapy may charge me $25.00 to be paid by me, not my insurance company and I could become subject to same day appointment or permanent discharge due to noncompliance of recommended treatment plan.

Patient Signature: _____ Date: _____

Patient Representative: _____ Date: _____

(If patient is a minor or, if authorized by patient)