Consent for Care & Treatment

I agree and give my consent for Integrated Physical Therapy to provide care and treatment considered necessary and proper in evaluating and treating _____'s physical condition.
(*Print Name of Patient)*
I authorize Integrated Physical Therapy to release any medical information to my referring or consulting physician that will communicate best with him/her the results of the physical therapist's evaluation and plan of care. I further authorize release of medical information to Integrated Physical Therapy from my physician(s) that may assist the Physical Therapist in my care, including results of diagnostic testing.

Initial _____

Benefit Assignment & Authorization to Release Medical Records

I hereby assign and convey directly to Integrated Physical Therapy, as my designated authorized representative, all medical benefits and/or insurance reimbursements, if any, otherwise payable to me for services, treatments, therapies and/or medications rendered or provided by Integrated Physical Therapy, regardless of its managed care network participation status. I understand that I am financially responsible for all charges not paid by my insurance company. I also authorize Integrated Physical Therapy to release all information necessary to secure the payment of benefits and/or insurance reimbursements. I further agree that a photocopy of this agreement is as valid as the original.

Initial _____

Appointment & Cancellation Policy

I understand that my doctor has prescribed physical therapy for me and that physical therapy is an ongoing process that requires regular attendance to be most effective.

At Integrated Physical Therapy, we schedule our patients to receive one-on-one time with the Physical Therapist each visit. Please be on time for your appointments so that you may receive the full benefit of your scheduled physical therapy treatment.

We require cancellation notification ***24 hours*** in advance of your visit. Failure to show for an appointment or cancellation without 24 hours notice will be subject to **a $50 charge**. We understand that there are unexpected emergencies or illnesses that may prevent 24 hours notice, but please notify us as soon as possible.

Authorization to Leave Messages

I authorize Integrated Physical Therapy to leave voice messages on the following phone numbers regarding appointments and account information. ***(Please Circle)***

Home Phone: Yes No **Cell Phone**: Yes No **Work Phone**: Yes No **E-Mail Address:** Yes No

I authorize Integrated Physical Therapy to discuss my care with: _____
(Name and Relationship/Phone#)

Patient/Guardian Signature: _____ Date: _____
(If the patient is under 18, the parent or guardian must sign.)