DAULTON
Physical Therapy
Total Body Balance

Treatment Consent Form

Please read and initial each Consent

Name:_____ Date of Birth:_____

Consent to Receive Services

_____ I hereby authorize Daulton Physical Therapy to render appropriate Physical Therapy services to the named above. I recognize and agree that I have the right to refuse treatment or terminate services at any time. I acknowledge that no guarantees have been made to me about the results of the evaluation and/or treatment to be provided in this clinic.

Consent for Authorization for Emergency Medical Services

_____ At any time while receiving services from Daulton Physical Therapy and in the event of any medical emergency, I authorize Daulton Physical Therapy or its employees/ contractors to provide or obtain such medical treatment as they deem advisable under the circumstances, and I agree to assume sole responsibility for all charges for such treatment.

Consent for Release of Medical Records

_____ I understand that my records will be shared with my referring and/or primary MD or Chiropractor unless I request otherwise. In addition, I hereby consent and request that copies of my therapy treatment records be provided to the following (could be attorney, coach, additional care provider) for the period of my current start of care date to discharge date: _____ _____ _____.

Please also verbally release medical information regarding my care to the following individuals (family members, coaches, trainers, etc.): _____ _____ _____

Consent for Financial Responsibility

_____I hereby authorize the release of any medical or other information necessary to process my medical claims and to obtain payment of benefits. I authorized my insurance company, attorney or 3rd party payer to assign all payment benefits directly to Daulton Physical Therapy for the services rendered. I understand that I am financially responsible to Daulton Physical Therapy for all charges whether or not paid by my insurance. I also understand that I will be responsible for any copay or deductible as defined by my insurer. I also understand that my remaining account balance will become due upon completion of care according to term of repayment. I will also pay any charges incurred for bounced checks, collection, and court and attorney fees. My signature below also indicates that I have read and understand completely the Daulton Physical Therapy Financial Policy (separate document)

Consent for MISSED VISIT / LATE CANCEL POLICY

_____ A $40 fee will be assessed for a missed appointment unless a 24-hour notice is given. This fee will not be covered by any insurance. Additionally, tardiness in excess of 20 minutes may result in rescheduling of the appointment for another time and may also incur a missed appointment fee. Please understand that this time has been reserved specifically for you.

HIPPA: I have read the Notice of Privacy Practices and I am aware I can request a copy.

Patient or Guardian Signature:_____ Date: _____

I have read, initialed and agree to the above statements and certify that the information given is correct to the best of my knowledge.

Patient Signature/Guardian _____ Date:_____