REFORM PHYSICAL THERAPY
Don't neglect your health, reform it

General Consent for Care and Treatment

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether to undergo any suggested treatment or procedure after knowing the risks and hazards involved.

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you are indicating that (1) you intend this consent continues in nature even after a specific diagnosis has been made and treatment recommended, and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right to discontinue services.

- I authorize the release of information requested by my insurance plan for payment.
- I authorize all insurance payments to be released to Reform Physical Therapy for services rendered and further understand that any outstanding balance is my responsibility.
- I authorize Reform Physical Therapy to contact me via phone call, text message, email, or other means of communication as necessary. I further understand I will have the opportunity to opt out of said communication at any time if I choose.
- I understand that it is my responsibility to provide accurate and up-to-date insurance information including any insurance plan or policy changes. I further understand that failure to do so may result in my insurance company denying payment for my claims rendered.
- I understand that my insurance benefits have been confirmed as a courtesy and are not a guarantee of payment, authorization, or network participation. I understand that Reform Physical Therapy is not responsible for any misinformation provided by my insurance plan.
- I understand that my Physical Therapist will create an individualized Plan of Care for me, and I am expected to be compliant with that plan to the best of my ability.
- I understand that Reform Physical Therapy requires me to keep a current, valid credit card on file for charges not covered by my insurance. I also understand that those charges may be a result of not meeting my deductible, cancellation/ no show fees, or payments reversed by my insurance company, and any other balance during or after treatment is completed. I further understand that Reform Physical Therapy will notify me before charging my credit card.
- I understand that Reform Physical Therapy reserves the right to bill a $50.00 cancellation fee for any appointment that is canceled with less than 24 business hours notice.
- I understand that Reform Physical Therapy reserves the right to charge a $50.00 fee for arriving to a scheduled appointment more than 10 minutes late.
- I understand that if I am unable to make it to my appointment due to the weather, I am expected to reschedule the appointment within the same calendar week, if possible, to avoid gaps in treatment and paying the cancellation fee.
- I understand that in the unlikely event my physical therapist is ill or misses work, my appointment may be changed to another therapist's schedule, with or without notice.
- I understand that a copy of the Notice of Privacy can be provided to me upon request.
- I understand that I have the right to have any questions regarding my treatment answered by my provider and I have the right to refuse treatment.

By signing below, I certify that I have read and fully understand the above statements and consent fully and

voluntarily to its contents.

Printed Name: _____

Signature: _____ Date: _____