



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 or not 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 that this consent is continuing 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 at any time 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 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 understand I will have the opportunity to opt out of said communications at any time, if I so 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 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 checked 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 reserves the right to bill a \$50.00 cancellation fee for any appointment that is cancelled with less than 24-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 make it to my appointment due to weather, I am expected to re-schedule 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: _____