Date:_____

Patient Name: _____Med Rec # / Account#_____

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION AND TERMS OF TREATMENT

I hereby consent to the use and disclosure of my health information for treatment provided to me by **Provider**, payment for services provided by the Provider or other health care providers and the operations of the Provider and others under certain circumstances. I understand that a more detailed explanation of the ways the Provider may use and disclose my health information is contained in the Notice of Privacy Practices of the Provider, a copy of which has been provided to me.

Authorization to Release Information

My signature below constitutes my permission for Provider to discuss my protected health information with following individuals:

_____	_____	_____
Name of Authorized Individual	Relationship	Phone#
_____	_____	_____
Name of Authorized Individual	Relationship	Phone#

Referring Physician/Practitioner:
_____

□ I authorize Provider to send a 'thank you' acknowledgement to my referring physician/practitioner that identifies me by name.

CONSENT FOR TREATMENT:
Knowing that I have a condition requiring treatment by Provider, I do hereby voluntarily consent to such treatment as deemed necessary in the judgment of Provider.

FINANCIAL RECORDS CONSENT AND INSURANCE ASSIGNMENT OF BENEFITS:
I certify the information given to me in applying for payment under Title XVIII of the Social Security Act or other financial carriers is correct. I assign payment directly to Provider for unpaid charges. I agree to pay Provider for these services and supplies according to its regular rates and charges at the time these services and supplies are rendered. I understand that I am responsible for any health insurance deductibles, co-insurance and any amounts not paid by my insurance carrier. If this account is delinquent, I agree to pay all expenses including, but not limited to collection fees, court costs and actual attorney fees incurred by Provider in collecting this account.

CONSENT FOR DISCLOSURE FOR DURABLE MEDICAL EQUIPMENT:
I consent to allow Provider to release my outpatient treatment records to durable medical equipment suppliers to simplify ordering my durable medical equipment. Specific information disclosed will be a

patient information face sheet, physician orders and selected information to process my durable medical equipment order.

CANCELLATION AND NO SHOW POLICY:
I understand that Provider is committed to providing all of your patients with exceptional care. When a patient cancels without giving enough notice or misses an appointment, that patient prevents Provider from providing care to another patient. A cancellation is considered to be late when the appointment is not cancelled at least 24 hours prior to the scheduled appointment. To encourage timely notification and reduce missed appointments, Provider has adopted the following policy:

First late cancellation or missed appointment: **$0 fee.**
Second late cancellation or missed appointment: **$25.00 fee.**
Third late cancellation or missed appointment: **$25.00 fee** plus, at Provider's discretion, cessation of further care to the patient.

I acknowledge that the foregoing fees are **not** covered by insurance and **must** be paid by me prior to the next scheduled visit.

Planned absences from scheduled therapy will not be considered cancellations or no-shows. If I provide notice of a planned absence, my on-going schedule may be placed on "hold" for up to two (2) weeks. I acknowledge that a renewed prescription and appointment schedule may need to be arranged depending on the length of time which has passed.

TELEPHONE CONSUMER PROTECTION ACT NOTICE:
In order to service your account or to collect any amounts I may owe, you may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in a charge to me. You may also contact me by sending text messages or e-mails, using an e-mail address I provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

My signature below indicates that I understand the terms of treatment by Provider.

Patient's Signature:
_____
Date: _____
Print Name: _____(**when patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required).**

Signature of Legal Representative:
_____
Date: _____
Print Name of Legal Representative: _____
Description of Legal Representative Authority: □ Parent □ Medical Power of Attorney (attach documentation)
□ Other _____ (Explain and Attach Documentation)