IMPACT
PHYSICAL THERAPY

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for Impact Physical Therapy to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition. I understand that I am financially responsible for payment of all services that are not paid by my insurance carrier. Should my accounts be referred to collection, I will be responsible to pay cost of collection, including legal fees.

RELEASE OF INFORMATION

I hereby authorize Impact Physical Therapy, LLC to obtain any and all medical records concerning my care from any physician, hospital or health care professional that has provided medical care to me in the past.

I also authorize Impact Physical Therapy, LLC practice to release any and all medical records concerning my care to any physician, hospital or other health care professional providing care to myself / and or child at any time.

By signing this form, I consent to the Practice's use and disclosure of my health information for treatment, payment and health care operations. I understand that I have the right to revoke this consent at any time in writing, but if I do, my revocation will not have an effect on any actions the Practice has already taken in reliance of this consent.

CANCELLATION AND NO-SHOW POLICY

If you are unable to keep a scheduled appointment, please notify us at least 24 hours in advance. We will make every attempt to reschedule your appointment. If you miss your appointment without calling in advance, you will be charged a $25.00 no-show fee. This payment takes effect on your second missed appointment without previous notice. All cancellations and no-shows are documented in your medical record. Case managers and referring physicians for worker's compensation patients are notified after each missed appointment.

HIPAA PRIVACY ACKNOWLEDGEMENT

I acknowledge that I have been given a copy of the Practice's "HIPAA Privacy Policy Notice", which describes the Practice's obligations to ensure the privacy of my health information. The HIPPA Privacy Notice also describes how the Practice may use and disclose my health information for treatment, payment and health care operations. I know that I have the right to review the Practice's HIPAA Privacy Notice and to ask questions about it. I understand that the Practice is required to maintain the privacy of my health information in accordance with the terms of its HIPAA Privacy Notice.
I further acknowledge that the Practice can change its HIPPA Privacy Notice n the future and that I can receive a copy of the Practice's current Privacy Notice at anytime.

Patient Name (print): _____

_____ _____

Signature of Patient/Guardian Date