AUTHORIZATION TO TREAT: I authorize the staff of Total Health Physical Therapy to perform all necessary tests and procedures to adequately evaluate and treat my current condition, as allowed by the practitioner's license and qualifications.
RELEASE OF MEDICAL RECORDS: I authorize Total Health Physical Therapy or my insurance company to release any information required for submitting or paying claims. I also authorize the release of my medical records to any physician or medical facility that needs them for ongoing care for this or future medical issues.
BENEFIT ASSIGNMENT: I understand that for those insurances for which Total Health Physical Therapy is a provider claims will be submitted for me. I hereby authorize my insurance benefits to be paid directly to Total Health Physical Therapy. I understand that I am responsible for any claim that is denied or the balance due if only partially paid. Accounts 120 days past due may be assessed a carrying charge and may be turned over to a collection agency.

ATTENDANCE AND CANCELLATION POLICY:

Two missed appointments, without prior cancellation will result in discharge from physical therapy. A new prescription will be required to return to therapy.

Please notify us as soon as possible if you need to cancel. This permits scheduling for another patient who needs it.

If you cancel three times you may be discharged from therapy. A new prescription will be required to return.

If you arrive 15 minutes past your scheduled time, you will be rescheduled.

NOTICE OF PRIVACY PRACTICES: We keep a record of the services we provide you. We will not disclose this information to others unless you direct us to or the law allows or requires us to. The "Notice of Privacy Practices" that we gave you describes in detail how and why your health information may be used and disclosed, and how you may access that information. The policy is also posted in the waiting room and can be accessed on our website (totalhealthptshelton.com) or another copy can be obtained in our office. Please read and be sure you understand it.

OPTIONAL AUTHORIZATION FOR TREATMENT OF A MINOR

I____, the parent or legal guardian of

______________________________do hereby authorize and consent to routine physical therapy testing, procedures, and treatment. Also, in the event it's deemed necessary and I cannot be reached, emergency medical treatment by appropriately trained personnel. This authorization shall be in effect until revoked by me in writing.

DATE;__________________**SIGNATURE:**________________________________

ACKNOWLEDGEMENT: I have read and understand the above policies.

DATE:__________________**SIGNATURE:**________________________________

Revised 09-2013