PATIENT CONSENT FORM

Patient's Name:_____

_____ **Consent**: I consent to and authorize Leverage Physical Therapy (including its employees and trainees) to administer physical therapy treatment under the direction and supervision of the physical therapist. I understand and am informed that, as in the practice of medicine, physical therapy may have some risks. I understand that I have the right to ask about these risks and have any questions about my conditions answered prior to treatment. I know it is up to me to inform the physical therapist/staff about any health problems or allergies I have, as well as medications I am taking.

_____ **Minor Patients:** The parent or guardian accompanying a minor is responsible for payment of services. Unaccompanied minors (under 18) will be denied non-emergency treatment, unless the parent or guardian has signed patient and financial responsibility forms.

_____ **Release of Information:** Leverage Physical Therapy releases patient health care information for purposes of treatment or payment, or to other health care organizations, as explained in our HIPAA Notice of Privacy Practice. I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.

_____ **No Guarantees:** I understand that the practice of physical therapy is not an exact science and that no guarantees have been made to me as a result of treatments or examinations by the physical therapist or supportive staff. I understand that no contract, guarantee, warranty, or promise concerning the results of the physical therapy services is made.

_____ **Collections:** If your account becomes delinquent, collection proceedings will occur and you will be 100% liable for any collection fees, attorney and court costs incurred by Leverage Physical Therapy to collect said fees from the Responsible Party.

_____ **Returned Checks/Liens:** Returned checks are subject to a $25.00 administrative charge as well as the bank's charge for bounced checks. In addition, the account will incur a 2% interest charge for balances >30 days.

_____ **No Show/Cancel/Late Policy:** Cancellations with less than 24 hours' notice will result in a $30.00 fee. Cancellations with less than 12 hours' notice, or no notice will result in a $45.00 fee. If you arrive late for your appointment, the therapists may not have the time to treat you or your therapy time may be reduced.

_____ The undersigned patient or Responsible Party acknowledges that he/she has read and agrees to the information printed above.

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE	RELATIONSHIP TO PATIENT	DATE