Allied Physical Therapy
Consent and Release Form

Patient Name_____
Date of Birth_____

PLEASE READ AND INITIAL ALL POINTS BELOW

_____ I understand and agree that if I need to cancel/change an appointment, I will give at least 24 hour Notice or, if ill, I will call by 8AM the day of my appointment.

- If we are unavailable, you may leave a message on our answering machine. Please do not text.
- We reserve the right to charge $36.00 if you miss or cancel your appointment without the 24 hour notice.
- Allied Physical Therapy reserves the right to discontinue treatment of a patient with a history of broken or missed appointments.

_____ I understand my physical therapy benefits, including any limitations, of my insurance plan.

- I understand that insurance co-pays, co-insurance, and deductibles are due at each visit. If I do not have insurance, I understand payment is due in full at the time of appointment.
- I understand and agree that I am ultimately responsible for the balance on my account for professional services rendered by Allied Physical Therapy. I understand that I am financially responsible in the event that all of some payment is denied or not covered by my insurance carrier(s) or other third parties that are responsible for payment.
- I request that payment of authorized benefits be made on my behalf to Allied Physical Therapy. If this claim is paid to the patient instead of the provider, I agree to endorse the check to Allied Physical Therapy or send payment directly to Allied Physical Therapy within the same day of receiving payment.

_____ I understand that **I can request a copy of the Notice of Privacy Practices at Allied Physical Therapy**. The notice is posted at Allied Physical Therapy and I can inquire about the practice's Notice of Privacy Practices at the front desk.

CONSENT FOR CARE AND TREATMENT

_____ I, the undersigned, do hereby agree and give my consent and authorization for Allied Physical Therapy to provide examination, treatments and services at Allied Physical Therapy to myself/designee. I realize and certify that no guarantee or assurance has been made as to the results that may be obtained for such examinations, treatments and services.

RELEASE OF RECORDS

_____ I authorize Allied Physical Therapy to release any and all requested information pertaining to treatment necessary to process a claim(s) for physical or occupational therapy benefits (Physician, Insurance Company, Attorney, Etc.). I authorize Allied Physical Therapy to obtain medical records / reports as they pertain to my diagnosis, treatment, prognosis and other pertinent data to my treatment.

_____ I authorize Allied Physical Therapy to release records to my spouse, parents, and adult children.

_____ I authorize Allied Physical Therapy to release records to _____.
(relationship _____)

_____ _____
Printed Name (Guardian if minor) **DOB**

_____ _____
Signature (Guardian if minor) **Date**