Deborah Weinstein M.A., P.T Physical Therapy
Services Consent Form

PATIENT'S NAME: _____

1. **CONSENT:** I consent to physical therapy services at Deborah Weinstein M.A., P.T. Physical Therapy Services I know if I have any questions about my care, I should be sure to ask the physical therapist about them. I know it is up to me to inform the physical therapist/staff about any health problems or allergies I have. I must also tell the physical therapist/staff about drugs or medications I am taking.

2. **RELEASE OF INFORMATION:** Deborah Weinstein M.A., P.T. Physical Therapy Services 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.

3. **INSURANCE:** I authorize the staff at Deborah Weinstein M.A., P.T. Physical Therapy Services to review my insurance coverage with my insurance company. **I understand that my insurance benefits are only a quote of benefits and not a guarantee of payment. I understand that what I am quoted by Deborah Weinstein M.A., P.T. Physical Therapy Services and/or my insurance company may differ from what I may owe at the conclusion of physical therapy**. **I understand it is my responsibility as the patient to know my insurance coverage. I authorize payment of my insurance benefits to be made directly to Deborah Weinstein M.A., P.T. Physical Therapy Services. I agree to pay in full any and all charges not covered by insurance or other benefits, such as electrodes, iontophoresis, and low-level laser. I understand that it is unlawful for Deborah Weinstein M.A., P.T. Physical Therapy Services to waive co-pays, co-insurances, and deductibles that are my responsibility. For any returned check, there will be a $25.00 fee added to my responsibility that will be included in your bill. If I do not pay my bill in the specified timeframe, then my balance will be sent to a collection agency and a 10% percent fee will be added to the unpaid balance and will be my responsibility.**

4. **NO GUARANTEES:** I understand that the practice of physical therapy is not an exact science and that no guarantees or promises have been made to me as a result of treatments or examinations by the physical therapist or supportive personnel. I understand that no contract, warranty, guarantee, or promise concerning the results of the physical therapy services is made. This consent to treatment form is not a contract, nor is it an offer to contract, nor is it an acceptance of an offer to contract.

5. **NOTICE OF PRIVACY PRACTICE:** I have read the Deborah Weinstein M.A., P.T. Physical Therapy Services Statement of Privacy Notice located on the wall of the waiting room and I understand that a copy of the notice will be provided to me upon my request.

6. **CANCEL/NO SHOW/LATE POLICY:** If you must cancel your scheduled appointment, a 24-hour notice is required. Ca**ncels with a less than 24-hour notice and no shows will result in a $50.00 fee applied to your account.** If you arrive 10 minutes or more late for your appointment, your therapist may not have the time to treat you or your therapy time may be reduced.

I certify that any and all information provided by me in furtherance of my application for health care benefits are true. I have read the front and the information on the back of this form. It has been fully explained to me and all of my questions about the form have been answered. I understand its contents.

_____ _____

Patient Signature/Date **Patient's Representative Signature/Date**