CONSENT FOR TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Patane & Associates Physical Therapy, LLC through its appropriate personnel, to perform or have performed on me, or the above named patient, appropriate assessment and treatment procedures relating to:

_____

I further authorize Patane & Associates Physical Therapy, LLC to release to appropriate agencies, any information acquired in the course of my or the above named patient's treatment.

PATIENT SIGNATURE:_____DATE:_____
(or parent if patient is a minor)

OVER THE COUNTER SALE OF MEDICAL SUPPLIES

There may be occasions when treatment protocols require the purchase of orthopedic appliance/soft goods to enhance or progress rehabilitation. In those instances, we do require payment at the time of service.

A claim will be filed with your insurance, and in the event we receive payment from your insurance company, a refund will be issued to you.

SIGNATURE:_____DATE:_____

CANCELLATION POLICY

We understand there are times when you must miss an appointment due to emergencies or obligations to work and family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting a much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a treatment, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance, you personally will be charged a **$30.00 cancellation fee**, (not your insurance company). If you should fail to show or call, you will be charged a **$50.00 no-show fee** (not your insurance company)**.** Should you cancel less than 24 hours prior to, or fail to show up for your scheduled initial evaluation, you will be held responsible for the evaluation fee.

If time permits, our staff <u>MAY</u> call to remind you of your scheduled appointment. However, should you not receive a reminder call, this will not be accepted as an excuse for a cancelled or no-show appointment.

We appreciate your understanding and cooperation.

PATIENT SIGNATURE:_____DATE:_____

In addition, if you miss two (2) scheduled physical therapy appointments without giving us the appropriate notice as outlined above, you will be discharged from physical therapy at Patane & Associates. Your subsequent scheduled appointments will be canceled. You will be given a list of outside physical therapy offices in the area to set up further treatment.

PATIENT SIGNATURE:_____DATE:_____