~Stay Ready Physical Therapy~

Consent for Treatment

Patient's name (please print): _____

I hereby agree and give my consent to medical treatment in treating my physical condition. I authorize release of any medical information needed to process my claim. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes that occur. I authorize release of payment directly to Stay Ready Physical Therapy regardless of participation in or out-of-network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs that are incurred.

Patient/ Guardian Signature:_____Date:_____

Cancellation and No-Show Policy

Thank you for choosing **Stay Ready Physical Therapy t**o provide your physical therapy needs. Please read the following two policies, initial each one, and then sign your name at the bottom of the page.

Cancellation Policy:
If you need to cancel a Physical Therapy appointment, please call us 24 hours prior to your appointment, so we have the opportunity to offer your appointment to another patient. If less than 24 hours' notice is given you will be charged a **$75** cancellation fee. For *Lien Agreements*, you will be charged a **$100** cancellation fee.

No-Show Policy:
If you do not show up for a scheduled appointment, you will be charged a **$75** no-show fee. For *Lien Agreements*, you will be charged a **$100** no-show fee.

These charges are in place because your vacant time slot is a missed business opportunity for the clinic. We are unable to bill insurance for the missed appointment fee.

I understand the terms of this form. I realize that I am financially responsible for charges incurred from cancellations or no-shows.

Patient / Guardian signature:_____Date: _____