DAULTON
Physical Therapy
Total Body Balance

Treatment Consent Form

Name:_____

Date of Birth:_____

Consent to Receive Services

___I hereby authorize Daulton Physical Therapy to render appropriate Physical Therapy services to the named above.I recognize and agree that I have the right to refuse treatment or terminate services at any time. I acknowledge that no guarantees have been made to me about the results of the evaluation and/or treatment to be provided in this clinic.

Consent for Authorization for Emergency Medical Services

___ At any time while receiving services from Daulton Physical Therapy and in the event of any medical emergency, I authorize Daulton Physical Therapy or its employees/ contractors to provide or obtain such medical treatment as they deem advisable under the circumstances, and I agree to assume sole responsibility for all charges for such treatment.

Consent for Release of Medical Records

___ I understand that my records will be shared with my referring and/or primary MD or Chiropractor unless I request otherwise. In addition, I hereby consent and request that copies of my therapy treatment records be provided to the following (attorney, coach, additional care provider) for the period of my current start of care date to discharge date:

_____ _____ _____.

I also consent to allow verbal release medical information regarding my care to the following individuals (family members, coaches, trainers, etc.): _____ _____

_____

Consent for Use of Texting:

__ I hereby authorize Daulton Physical Therapy to use text messaging as a means of communication and that NO marketing will be used by texting my phone. I also understand that I may OPT-out of this agreement at any time by contacting the office.

Consent for Financial Responsibility

_____I hereby authorize the release of any medical or other information necessary to process my medical claims and to obtain payment of benefits. I authorized my insurance company, attorney or 3rd party payer to assign all payment benefits directly to Daulton Physical Therapy for the services rendered. I understand that I am financially responsible to Daulton Physical Therapy for all charges whether or not paid by my insurance. I UNDERSTAND IT IS MY RESPONSIBILITY TO KNOW MY INSURANCE COVERAGE . I also understand Daulton PT will do a courtesy check of my coverage to help me understand the amount due per visit, however this will be an *estimate* as insurance policies will pay different rates based on my policy, and their contractual agreement with Daulton PT. I will be responsible for any Co-pay, Co-insurance, and deductible amounts as defined by my insurer. I will also pay any charges incurred for bounced checks, collections, and court and attorney fees.

**CO- PAYs: All co-pays are due at the start of each visit.

**CO INSURANCE: Co-Insurances (percentages) will be estimated and due at the start of each visit.

**DEDUCTIBLES: If I have a Deductible, I will be asked to make a payment toward this amount at each visit as insurance will NOT pay Daulton PT until this deductible is met. Daulton PT recommends $100 payments at each visit until this deductible is met. I understand that this will help pay down balances ahead of time so as not to create large balances due on my monthly statements. If any outstanding balances are due at each visit, I may be asked to make a payment toward high balances prior to scheduling more appointments. OR, I understand that I also have the option of setting up automatic monthly payments arrangements (during or after care). My Credit card information can be saved to my account. I understand that any remaining account balance will become due upon completion of care. I agree that any outstanding balance aged 60+ days may be subject to late charges. Any overages will be refunded promptly. My signature below also indicates that I have read and understand completely the Daulton Physical Therapy Financial Policy (that is a separate document available on the website or upon request.)

Consent for MISSED VISIT / LATE CANCEL POLICY

___ A $75 fee will be assessed for a missed appointment unless a 48-hour notice is given. This fee will not be covered by any insurance. Please understand that this time has been reserved specifically for you.

____ HIPPA: I have read the Notice of Privacy Practices and I am aware I can request a copy

I have read, initiated, and agree to the above statements and certify that the information given is correct to the best of my knowledge.

Patient or Guardian Signature: _____Date:_____