Outpatient Physical Therapy Consent

Name:_____ **Date Birth:**_____

Consent to Receive Services

I hereby authorize Synergy Rehab and Wellness to render appropriate outpatient services to the named above. I recognize and agree that I have the right to refuse treatment or terminate services at any time.

Authorization for Emergency Medical Services

At any time while receiving services from Synergy Rehab and Wellness and in the event of any medical emergency, I authorize Synergy Rehab and Wellness 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.

Release of Medical Records

I hereby consent and request that copies of my therapy treatment records be provided to the following for the period of my current start of care date to discharge date:

(Physician)_____

(Physician other)_____

(Family member) _____

Medicare Authorization

If a Medicare patient, I certify that the information given me in applying for payment under Title XVIII or Title XIX of the Social Security Act is correct. I request that payment of authorized benefits be made to Synergy Rehab and Wellness on my behalf.

Notice of Privacy Practices

I acknowledge that I have read a copy of the Synergy Rehab and Wellness Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by Synergy Rehab and Wellness and of my rights with respect to my health information. I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.

Financial Responsibility

I understand that I am financially responsible to Synergy Rehab and Wellness for all charges whether or not paid by my insurance. I also understand that I will responsible for any copay or deductible as defined by my insurer. I also understand that my remaining account balance will become due upon completion of care according to terms of repayment. I hereby authorize the release 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 Synergy Rehab and Wellness for the services rendered. I will also pay any charges incurred for bounced checks, collection, and court and attorney fees.

Missed Visit Policy

In an instance of a cancellation or no-show without 24 hours' notice, we reserve the right to charge you a $40 cancellation / no-show fee. This fee will not be covered by any insurance. Additionally, tardiness in excess of 20 minutes may result in rescheduling of the appointment for another time.

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

Patient Signature _____ Date:_____

Parent/Guardian Signature _____Date:_____