Susan Underwood Physical Therapy
Consent for Treatment

1. **Informed consent**: I understand that as a patient of Susan Underwood Physical Therapy:
    - I have the right to receive complete and current information concerning my diagnosis (to the degree known by Susan Underwood Physical Therapy), treatment, and any known prognosis. This information will be communicated to me by my therapist.
    - I have the right to accept medical care or to refuse treatment to the extent permitted by law and to be informed of the medical consequences if I refuse treatment. I understand that if I refuse recommended treatment, Susan Underwood Physical Therapy has the right to terminate the relationship with me.
    - I will be informed if Susan Underwood Physical Therapy wishes to participate in or perform any research or educational projects that would affect my care. I understand that I have the right to choose whether I participate, and that regardless of my participation, I will receive the most effective care the clinic provides.
    - Patient's Rights are posted in a prominent location at the clinic for my review, and I can discuss any questions or concerns with my therapist.
2. I understand that as a courtesy to patients, Susan Underwood Physical Therapy is contracted with and files claims to Blue Cross Blue Shield and Medicare. In the event that a patient has medical insurance through another company, claim forms will be provided in order to help the patient receive reimbursement**. It is in my best interest to call my insurance to confirm my "Outpatient Physical/Occupational Therapy" benefits, for the purpose of understanding any limitations or restrictions.**

3. I understand that Susan Underwood Physical Therapy does not accept responsibility for the collection of my insurance benefits or negotiating the settlement of a disputed claim**. I am responsible for all charges, regardless of anticipated insurance coverage.**

4. I understand that once my therapist has determined the nature of my issue, treatment plans will be discussed. The office staff may provide the estimated cost of treatment, at my request**. At the time of service, the patient is responsible for all deductibles, co-pays, co-insurance, and other charges not paid by the insurance company.**

5. **I understand that Susan Underwood Physical Therapy requests a 24 hour cancellation notice. Failure to attend an appointment may result in a $50 fee.**

6. I understand that if I feel my privacy rights have been violated, I have the right to make a complaint to Susan Underwood Physical Therapy in writing without fear of retaliation.

7. **Privacy Policy**: I understand that a copy of the Susan Underwood Physical Therapy Privacy Policy is posted in the clinic, and I can receive a copy of this privacy notice upon request or download from website. I also understand that as part of this organization's treatment, payment or health care operations, it may become necessary to disclose my health information to another entity (my doctor, insurance company, etc.) and I consent to such disclosure for these permitted uses, including via fax.

Is there anyone (i.e. family, spouse, children, or friend) involved in your care, or payment related to your care, with whom we may share your health information? Please list.

_____

Would you be interested in text message/email reminders? ◯ Yes ◯ No ◯ Text ◯ Email

If you chose text message, who is your cell phone provider? _____

I have read, understand, and agree to all the above.

Patient's Signature: _____ Date: _____