# Hamilton Physical Therapy

## Consent to Treatment Form

Patient Name: _____

Home Phone: _____ Email Address: _____

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We will bill your insurance company for you, as a courtesy. You will be financially responsible for the balance of your account.

INITIAL:

_____ I consent to evaluation and treatment by Hamilton Physical Therapy and realize that I have the right to refuse any procedure after having the risks and benefits explained to me.

_____ I authorize the release of information acquired in the course of my treatment including, but not limited to medical records, electronic media, oral communications to my insurance company, physicians and/or other third party payers.

_____ I authorize phone messages regarding my treatment and appointments to be left with persons or machines at the phone numbers that I have provided.

_____ I authorize and assign direct payment to Hamilton Physical Therapy for services rendered, by an insurance company and/or out of the proceeds of any settlement case.

_____ I agree to pay co-payments, deductibles, and any portions that my insurance company will not pay. I will pay at the time of service if I do not have insurance coverage.

_____ I agree to give at least 24 hour notice for any cancellations. A $40.00 fee may be applied, at the discretion of your therapist, for repeated no-shows and cancellations.

_____ A copy of the HIPAA Notice of Privacy Practices has been provided to me. (IN OFFICE)