Authorization For Medical And Therapeutic Treatment

Permission is granted to the physical therapist in charge of this patient's care to administer and order services deemed necessary in the diagnosis and/or treatment of this case. I consent to having photography or videography to aid in my treatments and release Prostaff Physical Therapy PLLC from any responsibility in connection with the taking of said photographs or videos. No guarantees have been made to the patient regarding the results of such care and treatment which are hereby authorized.

Authorization to Permit Payment of Health Insurance Benefits to Facility

Prostaff Physical Therapy PLLC and patient's attending physicians are authorized to release medical or other information related to outpatient, inpatient, or emergency care including any alcohol, drug, or mental health records, HIV infection and AIDS related complex records to Medicare, Blue Cross, or commercial Insurers for which patient may be entitled to health insurance benefits as necessary for Prostaff Physical Therapy PLLC and involved physicians to receive payment for services. The undersigned acknowledges responsibility and agrees to pay in full all remaining balances of unpaid charges due to deductibles, co-insurance, or absence of insurance benefits. Prostaff Physical Therapy PLLC is authorized to release any information required in order for an outside credit agency to collect this amount.

Authorization For Release of Information

I authorize Prostaff Physical Therapy PLLC to furnish my insurance companies and physicians any information which they may request regarding my treatment, including photocopies from my medical records necessary to complete my claim or as required by law for this treatment and continued care. I authorize Prostaff Physical Therapy PLLC my referring and any treating physicians to furnish information from my medical records pertaining to my medical care and continued treatment.

Waiver of Responsibility For Personal Belongings

Prostaff Physical Therapy PLLC is released from all responsibility for loss or damage to personal property, such as money or other items retained in patient's possession.

Acknowledgment Of Privacy Practices

The undersigned patient or legally authorized representative for the patient acknowledges that he/she has been given opportunity to review and or has received a copy of the privacy notice of Prostaff Physical Therapy PLLC.

Acknowledgement Of Cancellation/No Show Policy

I understand that I play a crucial role in my healing and physical therapy. Part of understanding this is that I understand that I've made a contract to attend my physical/occupational therapy appointments with my therapist. If I do not attend my appointment and/or do not give a 24 hours notice I am aware that I may be charged $60 for that missed appointment. This will be charged to my card on file if I cannot make a new appointment within the same week. Please be advised that missing three consecutive appointments without calling to cancel may result in a discharge from Prostaff Physical Therapy PLLC.

_____	_____	_____
Patient Signature (Parent/Guardian, if minor)	Date	Date of Birth

Consent For Treatment Of Minor Named Here: _____

I authorize Prostaff Physical Therapy PLLC to treat the minor patient named above while I am not present