Consent for Care and Treatment

I, the undersigned, do hereby agree and give my consent for Quartini Physical Therapy to furnish medical care and treatment to that is considered necessary and proper in diagnosing or treating his/her physical and mental condition.
________ *Initials*

FINANCIAL RESPONSIBILITY- RELEASE OF INFORMATION

• I understand that Quartini Physical Therapy is an out of network practitioner and that I am voluntarily choosing this practice for my treatment.
• I agree to pay the fee of $125.00 at the time of service.
• I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.
________ *Initials*

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I have had full opportunity to read the Quartini Physical Therapy Notice of Privacy Practices. I hereby give my consent to Quartini Physical Therapy to use and disclose my protected health information to carry out treatment, payment activities, and health care operations. This includes email transmission communication to medical personnel and patient designated persons. Indicated below are individuals whom Quartini Physical Therapy may speak to regarding my treatment.

Please list names and relationship:

1.________________________ 2.________________________ 3. ________________________

________ *Initials*

We may need to contact you. Do we have your permission to leave a confidential message by phone or email?

____Yes -- Home# _____________Mobile#____________ Work#____________ Email:____________________

____No

LATE CANCELLATION/NO SHOW FEE

Your appointments are very important to Quartini Physical Therapy and we are committed to helping you manage your care needs. We reserve your allotted time and respectfully request at least **24 hour notice for appointment cancellations**. Any appointment missed, late cancelled, or changed without 24 hour notice will result in a charge of $50.00.
________ *Initials*

SIGNATURE for CONSENT

By my signature below, I acknowledge that I have read, understand, and agree to the terms and conditions contained in the Consent for Care and Treatment, the Authorization to release all information necessary to secure payment, and the Consent For Use and Disclosure of Health Information.
________ *Initials*

____ ____________________

Patient / Guardian/Responsible Party Signature Date

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