THE WHOLE PT
COMPREHENSIVE THERAPEUTIC APPROACH

CONSENT FOR TREATMENT AND FINANCIAL POLICY

Patient Name: _____ DOB: _____

We would like to **THANK YOU** for choosing The Whole PT (TWPT).

CONSENT FOR CARE AND TREATMENT

I hereby consent to the provision of treatment by TWPT. I authorize TWPT to furnish treatment which is considered necessary and proper in diagnosing or treating my physical condition. It is possible that my participation in the visit could result in injury to me. I also acknowledge and fully understand that I am engaging in activities that may involve the risk of economic or other damages which might result from my own actions or omissions, from the actions or omissions of other parties, or from any of the activities I am asked to complete during this visit. I further agree that there may be other risks not known to me or not reasonably foreseeable at this time. Nonetheless, it is my desire to participate in this visit. Accordingly, I release, waive, discharge and covenant not to sue TWPT, any of its employees, representatives, officers, directors, shareholders, affiliates, administrators, agents, owners, or lessors of all equipment, all of whom are hereafter referred to as "Releasees", from demands, losses, or damages on account of injuries, including death or damage to property, caused or alleged to be caused in whole or in part by the negligence of the Releasees or otherwise.

I hereby authorize and designate the following individual to act in all matters in connection with my treatment by TWPT, including, without limitation, discuss my therapy plan of care, and schedule and cancel my appointments:

_____

First and Last Name Phone Number Relationship to Patient

FINANCIAL RESPONSIBILITY

I agree to be financially responsible to TWPT for any medically necessary therapeutic services that are deemed necessary.

ASSIGNMENT OF BENEFITS

By way of my signature below, I provide TWPT with my authorization and consent to use and disclose my protected health information for the purposes of treatment, payment and health care operations as described in the Notice of Privacy Practices.

PATIENT VALUABLES

I relieve TWPT of any responsibility for loss of clothing, money, valuables, or other items that I decide to keep with me while I am a patient. I also understand that TWPT will not be responsible and will not replace any property lost, broken, or stolen, which I decide to keep with me, or any property brought to me while I am a patient.

CONSENT TO RECEIVE EMAIL, TEXT MESSAGES, AND CALLS FOR APPOINTMENT REMINDERS AND OTHER HEALTHCARE COMMUNICATIONS

I consent to receive email, text messages, and calls from TWPT for my protected health care and other services at the email address and phone number(s), including my wireless number, that have been provided during the intake process. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system. I understand that providing an email address and/or phone number is not a condition of receiving treatment. I am aware that email communication can be intercepted in transmission or misdirected. I also understand that I may revoke my consent for contact at any time by directly contacting TWPT or utilizing the opt-out method that will be identified in the applicable communication.

Patient Name: _____ DOB: _____

MINOR ABLE TO CONSENT FOR CARE (IF APPLICABLE)

I am under 18 years of age and for the following reason(s)_____ I am entitled under State Law to consent to medical or other health services for myself, and if applicable, for my minor children without the consent of any other person: _____ Patient Initials (required if completing this section)

CERTIFICATION OF IDENTITY

I certify that I am in fact the individual I claim to be. I understand that the knowing and willful use of another individual's personal identifying information under false pretenses is a criminal offense.

FOR The Whole PT Office USE ONLY

Verification of the identity of the above-named party was made by:

☐ Current Driver's License or other Photo ID

☐ Current Health Insurance Card

☐ Other:

I have read this Consent for Treatment and Financial policy form or have had it read to me, and it has been explained to my satisfaction. I understand that this Consent for Treatment, Payment and Health Care Operations form may be valid for up to one (1) year from the date that I sign it and applies to all TWPT facilities.

_____ _____

Signature of Patient or Guardian (if patient is a minor) **Date**

_____ _____

Signature of TWPT Representative **Date**