Consent for Treatment
I agree and give Talaria Physical Therapy and Wellness (Talaria PT) permission to furnish physical therapy to myself or my dependent, which is considered necessary and proper to treat myself or my dependent's condition.

Initials_____

Assignment of Benefits
I authorize payment of medical insurance benefits to be made directly to Talaria PT on my behalf for physical therapy services rendered. I also authorize Talaria PT to release my protected health information for treatment and billing purposes.

Initials_____

Notice of Privacy Practices
I have received a written copy of Talaria Physical Therapy's Notice of Privacy Practices. The notice provides, in detail, the uses and disclosures of my protected health information that may be available by Talaria Physical Therapy, my rights as a patient, and Talaria Physical Therapy's legal duties with respect to my protected health information.

Initials_____

Financial Policy
As a courtesy, Talaria PT will pre-verify your insurance benefits. Please note, unless you have secondary insurance all co-pays, deductibles, and/or co-insurance is the patient's/guardian's (in the case of a minor) responsibility. Co-pays are due at the time services are rendered. Your deductible/co-insurance will be billed to you once we receive an 'explanation of benefits' from your insurance carrier. The responsibility for any services not paid by your health insurance is patient responsibility.
Payment methods include cash, check, money order and credit card. Returned checks and balances older than 90 days are subject to additional charges.

Initials_____

Cancellation/No-Show Policy Talaria PT
Talaria PT urges you to keep your appointments as consistent treatment will lead to a speedy recovery. Non-compliance may result in discharge from therapy. In worker's compensation or motor vehicle accident cases, noncompliance must be reported to your adjuster. The effect of non-compliance affects our clinic hours and other patients scheduling prerogatives. We require 24 hours notice if you need to cancel an appointment. Patients who fail to show for an appointment or that do not provide greater than 24 hours notice will be subject to a $30 charge.

Initials_____

Email authorization
I authorize Talaria PT to correspond with me via email. This may include but is not limited to newsletters and clinical updates.

Initials_____

Email: _____

Signature on File
I have read, gained understanding of, and agree with the above policies and procedures. I authorize this signature on all insurance submissions.

_____ _____

Patient's/Guardian's Signature Date