Welcome to CORE BALANCE Physical & Vestibular Therapy

Consent for Treatment

I acknowledge that the information I have provided is accurate and complete. I agree to have a licensed Physical Therapist perform an evaluation, establish a treatment plan, and render appropriate treatment. I also authorize the release of any pertinent information regarding my case to any insurance company, adjuster, physician, dentist, or podiatrist, or attorney involved in this case.

Privacy

In compliance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and our Notice of Privacy Practices, CORE BALANCE will not disclose your protected health information (PHI) without your explicit authorization, except as permitted by law for the purposes of payment, treatment, and health care operations. CORE BALANCE will limit the use and disclosure of PHI to the minimum necessary to accomplish the intended purpose and only disclose your appointment information, such as reminders or cancelations, on an answering machine, voice mail, text message or e-mail, unless you inform us otherwise. I acknowledge that I have received or have been offered a copy of the HIPAA Privacy Notice.

Attendance and Cancelation Policy

Therapy at CORE BALANCE means exceptional, personal, one-on-one physical therapy that is designed specifically for YOU to meet your goals. To receive the full benefits of treatment, it is important that you attend each of your sessions and arrive on time. The outcome of your treatment is important and success depends on consistency of your attendance. Your appointments are reserved at a specific time for you. Failure to keep your appointments is a lost opportunity to help you. Please call as soon as possible so we can reschedule your appointment. We require at least one full (24 hour) business day notice to avoid a cancelation charge.

A fee of $40 may be charged for an appointment cancelled with less than one full business day (24 hours) or for a no-show/missed appointment. This fee must be paid before the start of your next appointment. This fee is not billable or payable by insurance. After three (3) late cancels or no-show appointments, CORE BALANCE, has the right to discharge you from therapy back to your referring physician. We understand that emergencies do occur and each situation is unique and will take this into consideration.

By signing this form, I authorized CORE BALANCE, to initiate and deliver treatment of therapy services. I also have read and understand the attendance and privacy policies.

_____	_____	_____
Patient Name	Signature of Patient or Patient Representative	Date