BONNEY LAKE
Physical Therapy & Hand Rehab, PLLC

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Patient Consent Form for: **Patient's Name: _____**

Welcome to Bonney Lake Physical Therapy and Hand Rehab. We are committed to providing comprehensive rehabilitation services that restore physical function and improve quality of life. Therapy has been ordered for the patient named above. In order to initiate services, we need your signature on this authorization form. Please read and sign where indicated below.

Authorization for treatment and release of information:

1) I have been informed and consent for this provider to render the treatment set forth above as ordered by my physician.
2) I give authorization for therapy to be provided in areas not totally isolated from other patients and personnel.
3) I understand that I am free to choose my therapy provider independent of insurance plans, referring physicians and have elected to choose Bonney Lake physical Therapy & Hand Rehab as my provider.
4) This authorization, or photocopy of same, authorizes the release of medical information to provide effective quality and delivery of care: a) My medical providers, medical related facilities and claims managers for effective communication. b) My insurance company representatives including medical insurance, auto & workers compensation insurance necessary to process claims.
5) For any circumstance other than that listed in number 4 above, a separate signed authorization will be required to release any information. (fees may apply)

Reimbursement Coverage:

1) I request and authorize the patient's insurance coverage to make payments of authorized benefits on the patient's behalf directly to this provider.
2) I understand that I am ultimately responsible to pay for services provided to the patient including any of the following:
    a. a) Any applicable deductibles or co-payments.
    b. b) Any non-insured or non-covered services authorized above.
    c. c) Any charges in excess of payment limitations imposed by third party payers.
3) I understand that missed appointments without cancellations within our policy will be charged $35.
4) I understand that any amount not paid within 60 days along with any other attorney or collections fees associated with the account will be subject to a monthly billing service charge of 1%.

I have read and understand the above.

Signature of patient / representative: _____ Date _____

Consent for Photographs:

I hereby authorize Bonney Lake PT & Hand Rehab to take photographs of me for the use in treatment to monitor progress with my condition, to assess splinting and taping needs and for the use for educational purposes. I understand that none of my personal information about me will be disclosed for the privacy laws that are in place. I understand by giving my permission for the use of photographs will in no way hinder the quality of care provided. I hereby release Bonney Lake Physical Therapy & Hand Rehab from any liability associated with the use of the photographs provided and described above.

Signature of patient / representative: _____ Date _____

Notice of Privacy Practices:

I acknowledge that I have read/reviewed my rights regarding medical information pertaining to my treatment at Bonney Lake Physical Therapy and Hand Rehab. I understand that I can request a hard copy of my rights at any time.

Signature of patient / representative: _____ Date _____

Cancellation Policy:

We appreciate you keeping your advanced scheduled appointments. However, if you unexpectedly must cancel, please do so by 5:00pm the open business day (Monday-Friday) prior to your appointment. If you fail to show for your scheduled appointment or do not cancel within the stated policy you will be billed $35.00.

Signature of patient / representative: _____ Date _____

Please ask if you would like a copy of this form

If someone other than the patient has signed, please state your name and relationship to the patient:

Name: _____ Relationship to patient: _____