Consent to Treat

I consent to receive outpatient rehabilitation therapy services and any ancillary services that are deemed medically necessary or appropriate by my physical therapist and/or treating physician. However, I am aware that the practice of rehabilitation therapy is not an exact discipline and I acknowledge that no guarantees have been made to me regarding treatment and the treatment results from the rehabilitation therapy.

Patient/Guardian Signature _____ Date _____

I consent to allow the use of filming devices, such as a camera or cell phone, for the purposes of enhancing my care. In addition, I consent to the transmittal of such filming device images or video to you the patient and/or the treating physician through email or text. I acknowledge that such film and related images will only be used or disclosed for treatment purposes, and that Leah Schmitt Physical Therapy will not further use or disclose such film or images for any other purpose without my authorization or consent.

Patient/Guardian Signature _____ Date _____

Cost of Appointment

Evaluation= $200
45 minutes= $150
60 minutes= $200

Payment is due at the time services are rendered in the form of cash, check, or credit card. Please note, any checks returned as non-sufficient funds will incur a $25.00 fee.

Patient/Guardian Signature _____ Date _____

Medical Record Privacy

In compliance with the Health Insurance Portability and Accountability Act (“HIPAA”) Privacy Rule and our Notice of Privacy Practices, Leah Schmitt Physical Therapy 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.

Patient/Guardian Signature _____ Date _____

Leah Schmitt Physical Therapy Ltd.

Cancellation Policy

I strive to provide each patient with the highest quality of care while attempting to accommodate your schedule for your convenience. I realize that emergencies and other scheduling conflicts arise and are sometimes unavoidable, however, advance notification allows me to fulfill other patient's scheduling needs and keeps the clinic operating at is most efficient level. Due to my one-on-one treatments, missed appointments are a significant inconvenience to your physical therapy, the clinic and other patients. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

Late Cancellations: A late cancellation is considered when a patient fails to cancel their scheduled appointment with a 24-hour advance notice.

- **First late cancellation:** courtesy reschedule
- **Second and third late cancellation:** $50 fee will be billed to your account.
- No cancellation fee will be charged if the missed appointment is made up within the same week it was scheduled on a day that you do not have another appointment scheduled.

No Show Policy: A "no-show" is someone who misses an appointment without cancelling it in an adequate manner.

- **First missed appointment:** $100 deposit to reschedule
- **Second missed appointment:** $75 fee will be billed to your account
- **Third missed appointment:** $75 fee will be billed to your account, Furthermore, 2 consecutive no-shows will result in the cancellation of all remaining scheduled appointments.

Repeated failure to comply with this ATTENDANCE POLICY will result in your name being placed on a "**Schedule Based on Availability"** list. This will require you to call for an open appointment on each day you would like to receive therapy. We will do everything possible to accommodate you, as space on the schedule permits.

Patient/Guardian Signature _____ Date _____