INFORMED CONSENT AND STATEMENT OF FINANCIAL RESPONSIBILITY

1. CONSENT FOR TREATMENT: I consent to and authorize my physical therapist, occupational therapist, and other healthcare professionals and assistants who may be involved in my care, to provide care and treatment prescribed by and/or considered necessary or advisable by my physician(s)/health care provider(s). I acknowledge that no guarantees have been made to me about the results of treatment.

2. NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT: I have been given the opportunity to review Huling Physical Therapy's "Notice of Privacy Practices" which is displayed in the reception area. This notice of privacy practices provides information on the uses and disclosures of my protected health information. I understand that this notice is subject to change, and if changes are made, a revised copy of the notice will be posted in the reception area. I also understand that if I have any questions, I may contact the Privacy Officer at (662)-874-5964

3. RESPONSIBILITY FOR PAYMENT: All co-payments are due at the time of service. I acknowledge that in consideration of the services provided to me by Huling Physical Therapy, I am financially responsible for payment of my bill. I acknowledge that it is my responsibility to provide Huling Physical Therapy with current insurance information and to familiarize myself with my insurance plan and its policies. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan. My health insurance plan may provide that a portion of the charges and balance will remain my personal responsibility, such as my deductible, co-payment, co-insurance or charges not covered or denied by my health insurance, Medicare, or other programs for which I am eligible. PLEASE NOTE THAT REFUSAL TO SIGN THIS FORM DOES NOT CHANGE RESPONSIBILITY FOR PAYMENT IN ANY WAY.

4. ASSIGNMENT OF BENEFITS: I hereby assign to Huling Physical Therapy all my rights and claims for reimbursement under my health insurance policy. I agree to provide information as needed to establish my eligibility for such benefits.

5. ACCESS TO AND RELEASE OF HEALTH INFORMATION: I understand that Huling Physical Therapy may document medical and other information related to my treatment in electronic and other forms and that such information will be in the course of my treatment, for payment purposes and to support those who are caring for me. I authorize my clinician(s) and Huling Physical Therapy's administrative staff to contact other health professionals that may have information related to my prior and current health conditions and treatment. I acknowledge that I have received Huling Physical Therapy's Notice of Privacy Practices and that it outlines how my health information will be used and disclosed and how I may gain access to and control my health information.

6. APPOINTMENT REMINDERS: I also authorize the release of appointment information left in a voice-mail, answering machine or text message and understand that there is some level of privacy risk associated with these forms of communication.

7. HIPAA CONSENTS: In compliance with HIPAA regulations, I consent to the following individuals receiving verbal information regarding the billing of my account: (use the boxes provided below to list their names. If you do not wish for anyone then just leave blank)

Name: _____ Relationship: _____
Name: _____ Relationship: _____

By my signature below, I certify that I have read, and I understand and fully agree to each of the statements in this document and sign below freely and voluntarily.

Signature of Patient or Legally Responsible Person: _____

Date: _____ Printed Name of Above:_____

No-Show / Cancellation Policy Please Read Carefully

NO SHOW FEE $25.00 (When you don't attend or call to change your scheduled appointment) To avoid a no-show fee, you must call to reschedule your appointment before your appointment time. We make every effort to schedule our patients in a timely manner and repeated no shows take available spots from other patients who could schedule. Repeated No-Shows may result in being discharged from care after 3 missed sessions.

I acknowledge that I have reviewed the policy and understand that failure to complete any part of my treatment program will reduce my chances of success.

Signature of Patient/Guardian: _____ Date: _____