PATIENT INFORMATION CONSENT FORM

I have read and fully understand Health Check's HIPAA policies and procedures. I understand that Health Check may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice.

I hereby consent to the use and disclosure of information for purposes as noted in Health Check's HIPAA policies and my personal health procedures. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Signature of Patient/Guardian: _____Date: _____

CONSENT FOR TREATMENT

I or my representative, recognizing the need for care, consent to all services ordered or deemed appropriate by my physician and/or physical therapist.

Signature of Patient/Guardian: _____Date: _____

CANCELLATION/NO-SHOW POLICY

At Health Check, we want to provide you with the best treatment to attain your rehabilitation goals as quickly as possible. In order to do that, it is critical that you attend your prescribed/scheduled visits. We require 24 hours' notice if you need to cancel your appointment. When you cancel at the last minute or do not show up for your appointment, you not only are effecting your own treatment, but you are also preventing another patient from scheduling in that appointment time slot. **Therefore, if you cancel without 24 hours' notice and/or you do not show up for your appointment, you will be charged a $45 cancellation/no show fee which will be your responsibility to pay, and will not be billed to your insurance. If you have a credit card on file, we will charge it to that card automatically.**

Signature of Patient/Guardian: _____Date: _____