ON THE SPOT THERAPY

Physical Therapy Consent Form

PATIENT'S NAME: _____

1. **CONSENT:** I consent to physical therapy services provided by **On The Spot Therapy L.L.C.** I know if I have any questions about my care, I should be sure to ask the physical therapist about them. I know it is up to me to inform the physical therapist about any health problems or allergies I have. I must also tell the physical therapist about drugs or medications I am taking.

2. **RELEASE OF INFORMATION: On The Spot Therapy L.L.C.** releases patient health care information for purposes of treatment or payment, or to other health care organizations, as warranted. I authorize the release of any medical or other information pertinent to my case to any insurance company or physician for the purpose of processing claims and securing payment of benefits.

3. **PAYMENT:** I understand it is my responsibility as the patient to know my insurance coverage. Though NJ is a Direct Access State, my insurance provider may not cover Physical Therapy services without a prescription from a physician. I agree to pay in full any and all charges from **On the Spot Therapy L.L.C.** at time of service. I understand that my insurance may not reimburse me the full amount I have paid. For any returned check, there will be a $25.00 fee added to my bill.

4. **CANCEL/NO SHOW/LATE POLICY:** If you must cancel your scheduled appointment, a 24-hour notice is required. Please make every effort to make your scheduled appointment time.

I certify that any and all information provided by me in furtherance of my application is true. I have read this form. It has been fully explained to me and all of my questions about the form have been answered. I understand its contents.

_____ _____

Patient Signature Date