

Name (please print): _____ Date of Birth: ____/____/____

CONSENT FOR CARE & TREATMENT

I give my consent for Barnegat Sports Rehabilitation & Physical Therapy to provide me with the appropriate medical care and treatment as prescribed by my physician and/or deemed necessary by my physical therapist. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including any risks or alternatives to the treatment plan.

(Signature Patient or Guardian) (Date)

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I authorize any benefits payable under my insurance plan (including Medicare, if applicable) for services provided to be paid directly to Barnegat Sports Rehabilitation & Physical Therapy. I also authorize release of any information required in the course of my evaluation and treatment to the appropriate agencies.

(Signature Patient or Guardian) (Date)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Barnegat Sports Rehabilitation & Physical Therapy Notice of Privacy Practices. A copy of this document should be given to you at your initial visit.

(Signature Patient or Guardian) (Date)

CANCELLATION & NO-SHOW POLICY

Out of courtesy, we request 12 to 24 hours notice for all cancellations, so that your appointment time may be offered to another patient. We understand and accept that extraneous circumstances may arise; such as illness, emergency, etc. Thank you for your cooperation.

(Signature Patient or Guardian) (Date)

EMAIL

In the event that our therapists need to contact you via email for home exercises, appointments, or other clinical purposes, please provide us with your email as an alternate means to communicate with you.

(Email)