BEND & STRETCH
Pilates | Physical Therapy
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PATIENT CONSENT FORM

Name: (First) _____ (Middle Initial) _____

(Last) _____

TERMS & CONDITIONS – please CHECK boxes below & sign:

☐ I (or my dependent) have insurance coverage and assign directly to Bend & Stretch Physical Therapy LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand there may be services provided and/or recommended by my provider that my insurance company may identify as noncovered services. I am financially responsible for all charges whether or not paid for by insurance.

☐ I hereby authorize Bend & Stretch Physical Therapy LLC practitioner to release all information necessary to secure the payment of benefits and by signing below I authorize all insurance submissions. I understand that co-payments are due at the time of service.

☐ I hereby give my consent for Bend & Stretch Physical Therapy LLC to use and disclose my protected health information (PHI) to carry out treatment, payment, and healthcare operations. I have been informed of my rights to privacy regarding my PHI under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

☐ With my consent, Bend & Stretch Physical Therapy LLC may call, email, or mail to my home or other alternative location in reference to any items that assist in carrying out treatment, payment, or health care operations, such as appointment reminders, insurance items and any information pertaining to my clinical care.

☐ Bend & Stretch Physical Therapy LLC keeps a record of the health care services provided to you. You may ask to see and copy that record. Bend & Stretch Physical Therapy LLC will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so.

☐ I give permission for the following individuals to request & discuss treatment/account information regarding my medical care:

_____

☐ I authorize Bend & Stretch to mail, email, or fax the following information to the address, email address of fax number, per my request *(Optional)* to the following business/individual:

_____

☐ I understand that Bend & Stretch Physical Therapy LLC has a **24-hour cancellation policy** and that a **charge of $50** will be billed to me directly if I miss any appointment or fail to provide the required 24-hr notice when cancelling an appointment. I further understand that arriving late to a scheduled appointment may result in a shortened or rescheduled appointment. I realize that emergency do occur – late cancellation due to illness or family emergency won't be billed. You may cancel/reschedule your appointment online via our scheduling system, call/text our phone number or email.

☐ I understand that initial evaluation and subsequent visits last approximately 60 mins. Fees fluctuate depending on the procedure performed. Interest fees are applied to patient account exceeding 120 days past due. Patients are seen by appointment only and scheduling is based on a first come, first served basis on-line through www.bendnstretchpilatespt.com website, in person with me or by phone at 918-688-4403.

☐ I certify that the information provided on this form is true and correct to the best of my knowledge. I give permission for the Bend & Stretch Physical Therapy LLC practitioner to administer and perform such procedures as may be deemed necessary for treatment. By initialing above and signing below, I am indicating that I understand and agree to the above terms and conditions.

Patient Signature: _____ Date: _____

Parent/Guardian (if patient is under age of 18) _____Date: _____