CONSENT TO CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent to therapists at Sound Body Rehabilitation to furnish medical care and treatment to myself/child, considered necessary and proper in diagnosing and treating my/his/her physical condition. I understand that consultation with my doctor is recommended prior to treatment.

BENEFITS ASSIGNMENT/RELEASE OF INFORMATION

I, the undersigned, do hereby assign any medical and/or surgical benefits to include major medical benefits to which I am entitled to Sound Body Rehabilitation for this physical therapy assignment. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize Sound Body Rehabilitation to release all information necessary, including medical records, to secure payment for this assignment.

FINANCIAL/BILLING POLICY

It is the policy of Sound Body Rehabilitation to bill your insurance carrier as a courtesy to you. The benefits quoted to you or Sound Body Rehabilitation by your insurance company are not a guarantee of payment by them for our services. You are ultimately responsible for the charges, regardless of insurance payment or denial.

You are welcome to set up a payment plan. If payments are not made in a timely manner and the account becomes delinquent, the services of a collection agency or attorney on behalf of Sound Body Rehabilitation may be required. You will be responsible for all costs of collecting moneys owed, including court costs, collection agency fees and attorney fees.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Sound Body Rehabilitation maintains a record of the health care services provided to you. You may ask to see and obtain a copy of that record. You may also ask to correct that record. We will not disclose your records to others unless you direct us to do so or unless the law compels us to do so. You may see your records or get more information about it by contacting Michelle McPherson at 360-769-5944. Our Notice of Privacy Practices is provided to you and describes in more detail how your health information may be used and disclosed, and how you can access your information.

ATTENDANCE AND CANCELLATION POLICY

We are committed to providing you with excellent service and care. Your appointment time is reserved for you and only you because we believe you deserve a high level of care and attention. Please help us serve you better by honoring scheduled appointment times.

A 24-hour notice of cancellation is required. Cancellation of an appointment with less than 24 hours of notice and "no shows" will be subject to a fee. Please note that this fee is your responsibility, not that of your insurance company. Multiple missed or cancelled appointments may affect your ability to schedule future appointments.

I understand and agree to all of the above information and policies. I understand my financial responsibility for services rendered and missed appointments. I hereby acknowledge receipt of the Notice of Privacy Practices.

Signature____ Date ___________________

Print name ____ DOB __________________

4459 SE Mile Hill Drive, Port Orchard, WA 98366 Phone 360-769-5944/Fax 360-769-6250