Well Body Pt2, LLC

Consent, Statement of Financial Responsibility and Privacy

1. Consent for treatment: I hereby consent to, and authorize my physical therapist to provide care and treatment prescribed by my physician and/or considered necessary or advisable by my physician, physical therapist. I understand that bruising, reddening of skin, soreness after treatment and hematoma, including without limitation to myofascial work, internal muscle work and massage, stretching. I understand that it is my responsibility to inform my physical therapist if I experience any discomfort or pain during any treatment or if I have other unresolved concerns around my treatment. I understand that response to physical therapy varies from person to person and it is possible that treatment may result in aggravation of existing symptoms or may cause pain or injury.

2. Appointment attendance agreement: I understand the importance of attending therapy consistently, scheduling appointments in advance and arriving promptly for my appointment. I acknowledge that I may be rescheduled if I arrive more than 15minutes late for my scheduled appointment. I understand and acknowledge that appointment times given one week may not be available in subsequent weeks. I agree to provide at least 24 hours' notice when I need to cancel or reschedule an appointment and I understand that cancellation of, or failing to keep an appointment with less than 24 hours' notice will result in a cancel/no show fee of $75.

3. Self-pay agreement: I_____am signing this Self-pay agreement to indicate that I am seeking treatment from Well Body PT2 and I understand that this treatment will not be billed to my insurance company but I will pay in full on date of service. I may at later date turn my paid receipt of bill and requested documentation of visit including diagnosis and treatment codes to my insurance company on my own and request reimbursement. Well Body PT2 is only responsible for providing documentation of visit and receipt of paid bill.

4. I agree to pay Well Body PT2, LLC at the self-pay rate of $_____ per visit for each physical therapy session occurring after the date hereof for the current course of treatment and I will be required to pay that amount at each visit.

5. I understand that Well Body PT2, LLC will maintain my privacy to the highest standards and may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluation the quality of services provided and any administrative operations related to treatment or payment.

Patient name (printed):_____ Date:_____

Signature of Patient (Guardian/Guarantor if patient is minor): _____

Printed name of Guardian/Guarantor:_____