

Benefit Release Information: I authorize **Colleyville/Trophy Club Physical Therapy and Sports Rehabilitation, P.C.** to release any information necessary to my insurance carrier and/or their agents in order to determine benefits payable for related services. I authorize the payment of medical benefits for these services to **Colleyville/Trophy Club Physical Therapy and Sports Rehabilitation, P.C.** I also authorize the release of all clinical information to my referring physician and primary care physician so that he or she can be updated on my condition and the care I receive here.

Signature: _____ Date: _____
(If the patient is a minor, please have the parent sign here.)

Authorization of treatment: I authorize **Colleyville/Trophy Club Physical Therapy and Sports Rehabilitation, P.C.** to provide therapy services to myself or to _____(my legal dependent). I understand, I have the right to refuse therapy services at any time. I further understand no guarantees have been made by any representative of **Colleyville/Trophy Club Physical Therapy and Sports Rehabilitation** as to the outcome of this therapy.

Signature: _____ Date: _____
(If the patient is a minor, please have the parent sign here.)

HIPAA Privacy Practices Acknowledgement: I have received the notice of privacy practices and/or I have been provided an opportunity to review it.

Signature: _____ Date: _____
(If the patient is a minor, please have the parent sign here.)

Cancellations and No-Shows: We take this subject seriously, because it can make difference between whether you succeed in your treatment or not. Showing up for these visits is very important in achieving your goals in therapy. Our appointments are made for an hour or greater, therefore when you do not show or fail to give adequate notice of a cancellation we are left with a large gap in our daily schedule, when another patient might have needed an appointment.

We require 24 hours notice of a cancellation. It is your responsibility, when you call in, to have an alternative time in mind that will ensure you get in the full prescribed number of treatments that week whenever possible.

There will be a \$25.00 charge for a cancellation or no show without proper notice. This charge will not be covered by your insurance plan and is your responsibility. Worker's Compensation and PIP patients; documentation has to be made of any missed appointments and forwarded to your case manager and primary care physician.

Signature: _____ Date: _____
(If the patient is a minor, please have the parent sign here.)