Please carefully read the following statements and sign at the bottom indicating your understanding. If you have any questions, please inform one of our staff members. Thank you.

1. **CONSENT TO EVALUATION**: I hereby consent to the evaluation of my condition by a licensed Physical Therapist employed by Complete Care Rehab LLC. HIPAA I understand that, under the Health Insurance Portability Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I have read your Notice of Privacy Practices containing a more complete description of the uses and disclosure of my health information prior to signing this consent. I understand that the organization has the right to change the Notice of Privacy Practices and that I may obtain a copy of their practices at any time.
2. **PATIENT RESPONSIBILITY**: It is the patient's responsibility to inform Complete Care Rehab of treatment and medications at their initial evaluation.

• It is the patient's responsibility to inform Complete Care Rehab as soon as possible if there are any change to your insurance or your medical condition.

• Per health care regulation providers are advised to collect the co-payments and deductibles for each physical therapy visit as per your insurance plan & coverage. **It is the patient's responsibility to know about their own policies and coverage. If you have questions regarding what is covered for your physical therapy service contact your insurance provider.** Every plan has different coverage. By signing this form, you acknowledge that you are responsible for all charges NOT covered by your insurance.

• It is the patient's responsibility to inform Complete Care Rehab if the patient is under the influence of any substance or has a condition that may affect their safety while receiving treatment.

3. **CANCELLATION / NO CALL NO SHOW POLICY:** I understand that cancellations should be made at least 24 hours prior to my scheduled appointment time, unless extenuating circumstances prevent otherwise. This will allow us to accommodate other patients in need. If you miss a scheduled appointment or call in last minute you will be charged $25.00. This will be charged directly to you, not your insurance company.
4. **VOICEMAIL MESSAGES:**Do we have permission to leave messages that may contain detailed information regarding your appointments, billing, or treatment on your home or cell phone voice mail? Note: If you do not specify either home or cell we will assume your consent is for all telephone numbers listed on your registration. My signature on this form indicates that I have read and understand each of the above patient policies of Complete Care Rehab LLC. Additionally, I have addressed any concerns that I have with the policies. This form is essential to the function of Complete Care Rehab and I understand that by not signing this form I may be refused treatment.

Patient Name (Print)_____

Patient or Legal Guardian Signature_____

Date _____