



We welcome you to Core Specialized Physical Therapy. We would like to express our gratitude that you have selected our facility to provide your physical therapy treatment.

Consent for Care & Treatment

I agree and give my consent for Core Specialized Physical Therapy to provide care and treatment considered necessary and proper in evaluating and treating _____'s physical condition.
(Print Name of Patient)

I further authorize release of medical information to Core Specialized Physical Therapy from my physician(s) that may assist the Physical Therapist in my care, including results of diagnostic testing.

Patient/Guardian Signature: _____ Date: _____
(If the patient is under 18, the parent or guardian must sign.)

Benefit Assignment & Authorization to Release Medical Records

I give authorization for payment of insurance benefits to be made directly to Core Specialized Physical Therapy for services rendered. I understand that I am financially responsible for all charges not paid by my insurance company. I also authorize Core Specialized Physical Therapy to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement is as valid as the original.

Patient/Guardian Signature: _____ Date: _____
(If the patient is under 18, the parent or guardian must sign.)

Appointment & Cancellation Policy

I understand that my doctor has prescribed physical therapy for me and that physical therapy is an ongoing process that requires regular attendance to be most effective.

At Core Specialized Physical Therapy, we schedule our patients to receive one-on-one time with the Physical Therapist each visit. Please be on time for your appointments so that you may receive the full benefit of your scheduled physical therapy treatment. Late arrival of more than 15 minutes may result in a shortened treatment or cancellation of the visit.

We require cancellation notification 24 hours in advance of your visit. Failure to show for an appointment or cancellation without 24 hours notice may be subject to a \$25 charge. We understand that there are unexpected emergencies or illness that may prevent 24 hours notice, but please notify us as soon as possible.

Patient/Guardian Signature: _____ Date: _____
(If the patient is under 18, the parent or guardian must sign.)

Authorization to Leave Messages

I authorize Core Specialized Physical Therapy to leave voice messages on the following phone numbers regarding appointments and account information. (Please Circle)

Home Phone: Yes No **Cell Phone:** Yes No **Work Phone:** Yes No

I authorize Core Specialized Physical Therapy to discuss my care with: _____
(Name and Relationship)

Patient/Guardian Signature: _____ Date: _____
(If the patient is under 18, the parent or guardian must sign.)