Consent Form

I understand that if is my responsibility to be fully knowledgeable of my insurance benefits for physical therapy and co-payments are due at the time of service. I understand that my insurance company may not cover physical therapy if combined with other services such as chiropractic care. I will be responsible for any services denied for this reason.

If you FAIL to keep your scheduled appointment or do not cancel within 24 hours, we RESERVE the right to charge a $75.00 fee.

It is also my responsibility to inform McLaughlin Judd Physical Therapy, PLLC, as soon as possible of any changes to my insurance coverage during my course of physical therapy. Failure to do so may result in additional financial responsibility.

I authorize McLaughlin Judd Physical Therapy, PLLC, to release information as required by my insurance company to secure my insurance benefits. I understand I will be responsible for services not covered by my insurance company if I do not supply necessary referrals or prescriptions to secure payment of my account. A photocopy of this authorization shall be as valid as the original.

Patient Consent to Treat

I, the undersigned patient, consent to such treatment procedures as are deemed necessary by the provider, including those which are in addition to or different from those initially contemplated, and which are deemed necessary or advisable by the provider in the course of treatment.

Permission to Call and Leave Voice Mail Messages

I agree that this provider or its representatives may call and leave a voice mail message at my home or other number I provide them regarding appointments, billing or payment issues, or other information related to treatment, payment, or health care operations.

Permission to Discuss Protected Health Information Regarding Minors

I agree that the provider, his/her practice group, and their agents may discuss my child's PHI with the person accompanying my child. I agree that the provider may discuss PHI with both natural parents and stepparents. I acknowledge that state law may grant my child certain privacy rights regarding the child's PHI, and I have no right to receive this information.

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received from this provider a copy of a separate document, entitled, "Notice of Privacy Practices

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PATIENT SIGNATURE (or Personal Representative) DATE