Consent To Treatment

In signing below, I agree to be treated by the staff of Full Circle Physical Therapy as prescribed by my physician and recommended by my physical therapist. If I would become ill while undergoing treatment at Full Circle Physical Therapy, I give permission to the staff to administer treatments which they consider necessary to my well-being. I authorize the release of medical information to my insurance company necessary to process claims for services rendered by Full Circle Physical Therapy and to receive communication via email and/or text.

Patient's Signature: _____ Date: _____
(guardians signature if patient is a minor)

Cancellation/No-Show Policy

At Full Circle Physical Therapy, we pride ourselves on providing high quality care. In order to do so, we ask that you notify us 24 hours in advance to cancel and/or reschedule your appointment times. All appointments not kept without at least 24 hours notice are subject to a $25 fee. No-Show appointments (without any notice) are subject to a $50 fee. Thank you for understanding and your commitment to your recovery.

I, the undersigned, accept responsibility for my scheduled appointments, and I understand that I will be charged $25 for appointments that are cancelled without 24 hour advanced notice or $50 with no notice.

Patient's Signature: _____ Date: _____
(guardians signature if patient is a minor)

Financial Policy

We will bill your insurance as a courtesy; however, payment is required towards your deductible and/or co-insurance at each visit. I understand that I am responsible for understanding my health insurance benefits and determining if my insurance benefits and insurance policy covers the services provided by Full Circle Physical Therapy. I hereby authorize Full Circle Physical Therapy to release necessary information to process this claim. I further authorize my insurance benefits to be paid directly to Full Circle Physical Therapy and I understand I am financially responsible for all non-covered services. I am aware there is a $35 fee for any returned check.

Patient's Signature: _____ Date: _____
(guardians signature if patient is a minor)

Privacy Practice Acknowledgement

I have read and fully understand Full Circle Physical Therapy's Notice of Privacy Practices. I understand that Full Circle Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Full Circle Physical Therapy will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restriction.

Patient's Signature: _____ Date: _____
(guardians signature if patient is a minor)