Progressive Therapy Services
"a total body approach"

CONSENT TO EXAMINATION AND TREATMENT: INITIAL: _____

I hereby give my permission for Progressive Therapy Services, LLC to render examination and treatment to me/my dependent. I understand that I will be given all available pertinent information prior to the treatment being rendered. I will be given the opportunity to ask questions and to have them answered to my satisfaction. I understand that I may decline treatment at any time.

CONSENT TO RELEASE/OBTAIN MEDICAL INFORMATION: INITIAL: _____

Permission is hereby granted to Progressive Therapy Services, LLC to release information to my insurance company, employer, attorney, workers compensation carrier, physician/facility referred to for further treatment and/or my referring/family physician. Permission is hereby granted to any facility where I have previously been treated to release medical records to Progressive Therapy Services, LLC. We release information only to those people who need your information. We maintain physical, electronic, and procedural safeguards so that no one but persons involved in your health care or entities that need this information for claims processing have access to your Protected Health Information. I may revoke this medical information release at any time by notifying PTS in writing.

AUTHORIZATION FOR PAYMENT OF BENEFITS: INITIAL: _____

I authorize Progressive Therapy Services, LLC to bill my health insurance/ or Medicare for services rendered. All payments received will be applied to my balance. I will be responsible for all co-pays/co-insurance and deductibles that may apply. Although Progressive Therapy Services, LLC will help verify and assist me in understanding my benefits, it is ultimately my responsibility and I will not hold Progressive Therapy Services, LLC, responsible for any misrepresentation of insurance benefits. I understand that any charges not paid by my insurance company are my responsibility, and are due and payable by me.

AUTHORIZATION FOR CASH SERVICES: INITIAL: _____ N/A: _____

If therapy is provided at my request for cash services, I understand that payment for service will be my sole financial responsibility. I understand that payment is due at the time services are rendered.

CANCELLATION/ NO-SHOW POLICY: INITIAL: _____

In the event that an appointment needs to be cancelled or changed, we must have **24- HOURS NOTICE.** This allows us to accommodate other patients who are waiting for appointment times. If you do not relay to us within in a 24 hours (*regardless of reason)* you will be subject to a $50 fee that will be applied to your account. After two instances of broken appointments or short-notice cancellations, we have discretion to dismiss you from our practice.

NOTICE OF PRIVACY AND HOW WE PROTECT YOUR INFORMATION: INITIAL: _____
I acknowledge that I am able to ask for a copy of the **Notice of Privacy Practices** for Progressive Therapy Services, LLC.

_____ _____
SIGNATURE DATE