Consent for Treatment:

I hereby consent to treatment & care by Stodden Physical Therapy, LLC & health care providers associated with Stodden Physical Therapy, LLC. I am aware that although Stodden Physical Therapy, LLC, will do everything they can for the success of my treatment & wellness, it is not an exact science and no one has made any guarantees about the results of my treatments.

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Patient Signature	Parent or Guardian of Minor	Date

Acknowledgement of Notice of Privacy Practices:

The Notice of Privacy Practices is a complete description of my privacy rights as a patient of Stodden Physical Therapy, LLC. By initialing below, I acknowledge that I've been told I may see the notice at any time & may obtain a copy if desired.

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Responsible Party Initial

Authorization to Release Payment and Information:

I give permission to Stodden Physical Therapy, LLC. to release information about me, my health, the health services provided to me, or payment for my health services, that may be necessary (1) for my treatment (to healthcare providers or facilities that need the information for my continued care); (2) for any purposes related to payment by me or a third party for services (to determine eligibility, to process an insurance claim, for utilization and quality review, or for billing or collection purposes, as is necessary to obtain payment).

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Responsible Party Initial

Our Payment Policy:

As a service to you, all insurance will be billed by our office. I understand that an insurance company may not pay the full amount of my charges and I may be responsible for the amount not paid. If I do not have health insurance or have not provided current or accurate insurance information, I am responsible for all charges. If self-pay, I am responsible for the amount agreed upon in advance.

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Responsible Party Initial