

CONSENT FOR TREATMENT / NOTICE OF PATIENT INFORMATION PRACTICE

I or my representative, recognizing the need for care, consent to all services ordered or deemed appropriate by my physician and or physical therapist. I have received and fully understand the MDR Physical Therapy Inc., dba AGILITY SPINE AND SPORTS P.T. Notice of Privacy Practices. I understand that AGILITY SPINE AND SPORTS P.T. 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 AGILITY SPINE AND SPORTS P.T. will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions. I hereby consent to the use and disclosure of my personal health information for purposes as noted in AGILITY SPINE AND SPORTS P.T.'s notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

CANCELLATION POLICY

We, at Agility Spine and Sports P.T. take your time and treatment seriously. It is important to the progression of your treatment that you attend all your appointments. I understand that cancellations WITHOUT 24-hour in advance notice or "no-shows" will be subject to a \$50.00 office fee. Your insurance (even worker's comp) does not cover this fee. I understand that if my insurance company does not cover supplies utilized in my treatment I will be held responsible for them.

I have read and understand all the information provided above. I also understand that I am ultimately responsible for the balance of professional services rendered. All the information I have given to AGILITY is true and correct to the best of my knowledge. I agree to notify AGILITY SPINE AND SPORTS P.T. of any changes of my insurance and information provided.

(PLEASE PRINT PATIENT NAME)

(SIGNATURE OF PATIENT/LEGAL GUARDIAN)

(TODAYS DATE)

(GUARDIAN NAME)