CONSENT FORM

Kinesis Physical Therapy, LLC
9707 Medical Center Drive
Suite 330
Rockville, MD 20850
p (301) 444 - 4090 f (301) 444 - 4091
www.kinesispts.com

Name: ____
Last First MI

Consent to Treat and Release of Information

I hereby consent to and authorize all therapy treatments, which in conjunction with the judgement of my attending physician, may be considered necessary and/or advisable for the diagnosis and/ or treatment of the patient named above at Kinesis Physical Therapy, LLC. I authorize Kinesis Physical Therapy to release information, verbal and written, contained in my medical record to my insurance company, case managers, assignees and or beneficiaries as it relates to my treatment and or payment.

Signature: ______________________________ Date: ______________
(PARENT OR LEGAL GUARDIAN MUST SIGN IF PATIENT IS UNDER 18 YEARS OF AGE)

Relationship to Patient: ☐ SELF ☐ PARENT ☐ LEGAL GUARDIAN

Payment Guarantee

I agree to pay Kinesis Physical Therapy, LLC for the services provided to me. I understand and agree that the insurance claim forms will be submitted to my insurance company and that I am responsible for all unpaid and outstanding charges regardless of my existing coverage. I also understand that I will be responsible for any co-pays and/ or coinsurances at the time of service.

Signature: ______________________________ Date: ______________
(PARENT OR LEGAL GUARDIAN MUST SIGN IF PATIENT IS UNDER 18 YEARS OF AGE)

Relationship to Patient: ☐ SELF ☐ PARENT ☐ LEGAL GUARDIAN

Appointment Policy

I understand that my doctor has prescribed therapy for me and that physical therapy is an on-going process which require regular attendance to be optimally effective. I understand that if I am late for an appointment, I may have to reschedule my appointment or may have to accept an abbreviated treatment for that day. I understand that if I cancel or no show for three consecutive appointments, Kinesis Physical therapy has the right to discharge me from care for being non-compliant with my physician's orders.

I understand and agree that Kinesis Physical Therapy requires 24-hour advance notice of cancellation. If I fail to give 24-hour notice of cancellation or fail to show up for an appointment, I may be subject to a **$50** charge (which is not covered by insurance).

Signature: ______________________________ Date: ______________
(PARENT OR LEGAL GUARDIAN MUST SIGN IF PATIENT IS UNDER 18 YEARS OF AGE)

Relationship to Patient: ☐ SELF ☐ PARENT ☐ LEGAL GUARDIAN

Signature of Witness: ______________________________ Date: ______________

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