Nishati Physical Therapy/Sports Performance & Wellness

Consent and Statement of Financial Responsibility

1. CONSENT FOR TREATMENT: I consent to and authorize my physical therapist and other healthcare professionals, assistants and aides to provide care and treatment prescribed by and/or considered necessary or advisable by my physician(s)/health care provider(s). I acknowledge that no guarantees have been made to me about the results of treatment. _____(**initial**)

2. APPOINTMENT ATTENDANCE AGREEMENT: I understand the importance of attending therapy consistently and arriving promptly for my appointment. I acknowledge that I may be rescheduled if I arrive more than 15 minutes late for my scheduled appointment. I agree to provide **at least 24-hrs** prior to your scheduled appointment by phone or email. If you fail to keep your appointment or do not cancel 24-hrs prior to your appointment time, you may be subject to a **$25** late cancellation/no-show fee. All notices must be given in the form of a phone call/voicemail to our office (626) 808-4012 or email: NishatiPT@gmail.com. _____(**initial**)

3. FINANCIAL POLICY: All patient costs/fees are due at the time of treatment.

Cash-Pay Policy: We offer a prompt pay rate for services paid in full at the time of service. This discount is based on the administrative savings to our practice when receiving payments up front, rather than billing for services. We will not bill your insurance company for services provided under this arrangement. We can provide a superbill for you to submit to your insurance if you choose to do so. _____(**initial**)

Unaccompanied Minors Policy: Nishati Physical Therapy is authorized to provide treatment to a minor as appropriate when they arrive at an appointment unaccompanied by a parent/guardian; this may include changes in the current therapy the minor is receiving including treatments and exercises. The above financial policy is applicable to guarantors of an unaccompanied minor._____(**initial**)

4. CONSENT FOR EMERGENCY CONTACT INFORMATION
Person to contact in case of an emergency:

_____	_____	_____
Name	Telephone Number	Relationship

By my signature below, I certify that I have read, understand, and fully agree to each of the statements in this document and sign below freely and voluntarily.

_____	_____
Signature of Patient or Legally Responsible Person	Date
_____	_____
Printed Name of above	Date