Informed Patient Consent:

1. **Consent For Treatment:** I consent to the evaluation and treatment deemed appropriate and necessary for my current condition. Provided by a licensed Physical Therapist employed by Evolution Physical Therapy and Wellness. The Physical Therapist will explain the nature and purpose of these procedures and the course of treatment. The Physical Therapist will inform me of the expected benefits, Complications, risks, and consequences of no treatment.
2. **Financial Responsibilty: Assignment of Benefits, Insurance Proceeds and Fee for Service:** I authorize Evolution Physical Therapy and Wellness to bill my insurance provider for services rendered and directly related to my care. I authorize payment of benefits to be directed to Evolution Physical Therapy and Wellness. I understand that ultimately I am responsible for the services rendered and the fee associated. I agree to pay my deductible, co-insurance and any charges not reimbursed by my insurances carrier. I agree to pay my co-pay, as determined by my insurance plan, at the time of service.
3. **Release of Information:** I authorize Evolution Physical Therapy and Wellness to obtain and release medical and/or needed the information required by insurance companies or any other agencies to determine payment and reimbursement of charges for service. I authorize the release of any medical information to and from my primary care physician, diagnostic centers and consulting physician or healthcare providers participating in my care, in order to properly establish a plan of care with Evolution Physical Therapy and Wellness. I authorize Evolution Physical Therapy and Wellness to contact and release my personal health information in the event of a medical emergency.
4. **Cancellation/No-Show Policy:** I understand that the time set aside by Evolution Physical Therapy and Wellness is reserved for my care. I acknowledge that Evolution Physical Therapy and Wellness reserves the right to charge a $50 fee in response to my late cancellation or No-show. I will provide Evolution Physical Therapy and Wellness with 24-hour notice of cancellation in order to forgo said $50 fee. If two consecutive appointments are missed without notification to our office ("No-showing") all future appointments will be canceled. Please understand this fee is your (the patients) responsibility, insurance companies will not reimburse for missed appointments.
5. **Reminder Calls:** To best accommodate our patients, we would like to know how you want your appointment reminder done☐ Personal Call☐ Automated Call☐ Text☐ Email☐ No Reminders
   Confirm Phone Number or Email: _____

_____ _____ _____
Print Name Signature Date

6. **Privacy Notice (HIPPA):** I have read and fully understand Evolution Physical Therapy and Wellness Notice of Privacy Practices. I authorize the disclosure of my personal health information for the purpose of carrying out treatment or payment. I understand I have the right to restrict how my personal health information is used and can revoke this consent at any time. I acknowledge by signing below that Evolution Physical Therapy and Wellness has offered me a copy HIPPA notice. At any time, I can request a copy of the HIPPA Document.

_____ _____ _____
Print Name Signature Date