B. WISE
REHABILITATION

Consent for Treatment

I hereby consent to and authorize my physical therapist and other health professionals involved in my care at B. Wise Rehabilitation PLLC to provide care and treatment that is considered medically necessary or advisable. I understand that this treatment may involve bodily contact, techniques - such as IASTM - that may cause bruising or skin discoloration, and activity that may cause soreness during and after treatment. I acknowledge that response to physical therapy varies from person to person and that treatment may possibly aggravate existing symptoms or result in new symptoms. Some diagnoses may involve internal assessment and treatment of the pelvic floor muscles, and I will verbally and distinctly inform the treating therapist if I would prefer to defer this treatment - acknowledging that this may limit full treatment capabilities and improvement for my condition.

I hereby release, discharge and acquit B. Wise Rehabilitation PLLC, it's agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and/or medical service, including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services.

Agreement of Financial Responsibility

All co-pays, self-pay services, and wellness package purchases are due at the time of service. I agree that I am financially responsible for payment of my bill, and that it is my responsibility to provide B. Wise Rehabilitation with my current and up-to-date insurance information (noting wellness packages are not billable to insurance).

I acknowledge that it is my responsibility to familiarize myself with my current insurance plan, what is required under my policy, and direct any questions regarding my heath coverage to my insurance carrier. My current health plan may include a deductible, co-pay, co-insurance or other charges not covered/denied, and these will be my financial responsibility.

I agree that if I fail to make any payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

I hereby assign all benefits directly to B. Wise Rehabilitation PLLC and authorize release of any medical records necessary to facilitate and process medical claims and as otherwise permitted or required of the Notice of Privacy Practices.

Cancellation Policy

Occasionally our patients need to cancel or reschedule their appointments. Our policy is that all cancels and adjustments to your appointment schedule be made with at least 24 hours notice. Cancelations made within the 24 hour time frame will be subject to a $40 fee. This fee is not covered by insurance. If you arrive more then 15 minutes late for your scheduled appointment, you may be rescheduled at the discretion of your therapist.

By signing, I acknowledge that I have read and understand the above, and that I agree to the stated terms:

Full name: ________________________________

Signature: ________________________________ **Date:**____________________