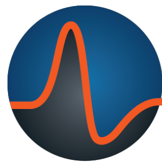

Client Name: ____ DOB: ____________

Statement of Patient Financial Responsibility

Action Potential, LLC, is pleased to be your physical therapy provider. The services you have elected to receive imply a financial responsibility on your part. This responsibility obligates you to ensure payment in full of our fees prior to or on the date services are performed.

By signing below, I acknowledge that, under no influence by the staff of Action Potential, I have decided to pursue physical therapy without using medical health insurance benefits. I understand that this means no insurance company will be billed for any services I receive, and that I am fully responsible for full payment. If you would like to submit your charges to your insurance company, we will be happy to provide you with necessary paperwork indicating services provided under our care.

_____ **(initial) Your payment amount and details:** ____

Office Policies

_____**(initial)** There will be a **$25.00** penalty assessed for any returned check.

_____**(initial)** We request 24 business hours notice for all cancellations due to our one to one policy. Cancellations made in less than requested time allotment will result in a **$50.00** charge.

Consent to Treatment

_____**(initial)** I hereby consent to evaluation and treatment (onsite and virtual) by the therapists at Action Potential, LLC.

_____**(initial)** I consent that information regarding my care may be communicated via voicemail/text and/or email.

_____**(initial)** I consent to being photographed or video taped for the purpose of patient education, instruction, and development of a home exercise program. I am aware that media specific to my plan of care will be placed in my medical record as protected health information and only disclosed to me. Media will not be disclosed further without my consent.

_____**(initial)** I give my permission and would like to be contacted about continued after care programs.

Client Signature: _____________________________________ **Date:** ____________

Client Representative: _________________________________ **Date:** ____________

(If patient is a minor, or if authorized by patient)