Phone: (256) 509-4398 ♦ Fax: (800) 317-4728
*karen@Therapy-A.com ♦ www.Therapy-A.com*

**Consent for Evaluation, Treatment and Services:**

- I voluntarily consent to receive treatment at Therapy Achievements and permit them to treat me in ways they judge to be beneficial to me.
- I understand I have the right to ask questions and the right to withdraw my consent for treatment or tests.
- I understand that therapy is not an exact science and no guarantee can be made as to the results of the evaluations and treatments provided by Therapy Achievements.
- I agree that all therapists involved in my care are responsible and liable for their own acts and omissions, and that Therapy Achievements is not responsible or liable for the acts or omissions of the aforementioned.

**Assignment of Insurance Benefits / Promise to Pay**

- I authorize Therapy Achievements to bill for and directly receive payment for services rendered.
- I understand that if I am receiving home health services, my insurance will not cover services provided by Therapy Achievements.
- I understand that Therapy Achievements is not responsible for determining my insurance coverage, but provides this service as a courtesy. However, I understand that this information may not be completely up-to-date and that it is my responsibility to call my insurance company and verify my coverage.
- I agree to pay Therapy Achievements for any services that are not covered by my insurance.

- **There will be a $30.00 charge per case for no-shows and or cancellations without 24 hours' notice.**

**HIPPA Privacy Practices Acknowledgement Form**

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

**Financial Hardship**

Therapy Achievements abides by the contractual and legal obligations of health benefit plans to collect charges, co-pay, co-insurance, and deductible amounts owed by patients. It is Therapy Achievements policy to screen requests for discounts, delayed payment plans, or forgiveness of debt based on individual circumstances. In order to do this, we must ask for certain financial information. All information will be held confidential as per Therapy Achievement's privacy policy.

**Consent for Photos and Video**

I consent to being photographed or videotaped for medical and medical record documentation purposes, provided said photographs or videotapes are maintained and released in accordance with protected health information regulations.

**Personal Valuables**

I understand that Therapy Achievements is not responsible for the loss or damage to any articles of personal property.

Signing below means that you have received and understand this notice. You also receive a copy.

| Patient's Signature or Legal Representative | Date |
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