BODYSCAPE
INTEGRATIVE PHYSICAL THERAPY

2024
Patient Signature Update

PATIENT NAME: _____

Consent for Care and Treatment
I, the undersigned, hereby agree and give my consent for BodyScape Integrative Physical Therapy to furnish care and treatment considered necessary and proper in treating my condition.

Authorization for Signature on File and Release of Information
I, the undersigned, hereby authorize the office of BodyScape Integrative Physical Therapy to affix my name to any and all claims or documents as related to any and all health benefits due to me. I authorize the release of any information relating to my health care claims. A photostatted copy of this authorization shall be as valid as an original.

Authorization for Assignment of Benefits
I, the undersigned, hereby assign all medical benefits, to which I am entitled, to the office of BodyScape Integrative Physical Therapy, and I shall be financially responsible for any unpaid balance. In the event payment is made directly to me for services rendered by this office, I recognize the obligation to promptly remit payment to this office. I hereby authorize and instruct my insurance company to pay by check and mail directly to BodyScape Integrative Physical Therapy.

Financial Responsibility
I understand and agree that if it becomes necessary to commence legal action, I am responsible for all costs of collecting moneys owed including court costs, collection agency fees and attorney fees, in addition to my outstanding account balance. I further understand that balances over 60-days will be subject to 1.5% finance charge, for which I am personally liable.

Cancellation Policy
Specific time is reserved for you when you schedule an appointment. If you cannot keep your scheduled appointment, please give us at least 24 hours notice so that we may reschedule your appointment and offer the reversed time to another patient. **There will be a charge of $50.00 for NO SHOW appointments or cancellations with less than 24-hour notification. If you need to cancel an appointment that is scheduled on a Monday, you must give notice of cancellation no later than 5:00pm on the preceding Friday.** I understand that I will be personally responsible for any cancellation fees.

I have read and fully understand all of the above information and hereby agree to comply as outlined above.

_____ _____
Signature Date

3018 E. Colorado Blvd., #100, Pasadena, CA 91107 TEL: 626-449-3900 FAX: 626-449-4505

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Patient Information Acknowledgement Form

I have read and fully understand Bodyscape's HIPAA Notice of Privacy Practices. I understand that I have the right to restrict how my protected health information is used and disclosed for treatment, payment and healthcare operations if I notify the practice. I also understand that Bodyscape will consider requests for restriction on a case by case basis but does not have to agree to requests for restrictions.

I understand that I also have the right to inspect and copy any information used for purposes as noted in HIPAA Notice of Privacy Practices, and to receive an accounting of certain disclosures Bodyscape has made, if any, of my protected health information.

I hereby consent to the use and disclosure of my protected health information for purposes as noted in HIPAA Notice of Privacy Practices handout that I received. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____
Patient Name

_____
Signature

_____
Date

Bodyscape is required by law to maintain the privacy of and provide individuals with notice of our legal duties and privacy practices with respect to your protected health information.

Bodyscape reserves the right to change the terms of this notice. This notice was published and becomes effective on January 1, 2014.