

## **Maple Leaf Physical Therapy PLLC, Consent and Policy Agreements**

**Please read, print name, sign and date below to acknowledge all sections**

**1. Consent for Treatment:**

I consent for treatment procedures and patient care with, in the judgement of my physical therapist and/or physician, may be considered necessary or advisable while a patient at Maple Leaf Physical Therapy PLLC. I have provided all pertinent information and answered all questions to the best of my knowledge and have read, understood and agree to this consent for treatment.

**2. Cancellation Policy:**

Patients are seen by appointment only at Maple Leaf Physical Therapy PLLC and 24-hours notice by phone or email is required for any cancellations to enable Maple Leaf Physical Therapy PLLC to schedule a patient who is waiting for an appointment. I understand my scheduled appointment time is specially reserved for me to receive one on one care, and I agree to give 24-hours notice for any cancellation. If I fail to give 24-hours notice for a cancellation then I agree to pay a fee of \$60. I understand that this fee will need to be paid at the time of my next appointment, and that insurance carriers will not pay for missed or cancelled appointments.

**3. HIPPA Notice of Privacy Policy:**

An opportunity to review and question a detailed copy of Maple Leaf Physical Therapy PLLC's Notice of Privacy Policy has been given to me and I understand that I can request a hard copy of the policy at any time and that a copy is posted in the clinic. I understand the Notice of Privacy Policy describes the types, uses and disclosures of my protected health information that may occur in the treatment, billing/payment for services, or in the clinic operations including coordinating or facilitating my care with another health care provider. I understand that the Notice of Privacy Policy also describes my rights and the responsibilities and duties of this clinic with respect to my protected health information. I understand that I have the ability to request in writing to restrict how the clinic uses or discloses my protected health information, and to revoke this consent at any time for all future transactions with the understanding that any such revocation shall not apply to the extent that the clinic has already taken action in reliance on this consent. I also understand that if I revoke this consent at any time, Maple Leaf Physical Therapy PLLC has the right to refuse to treat me.

**I have read and agree to the policies above:**

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**Print name**

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**Signature**

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**Date**