

**Client Information: Please Print**

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please be advised of the policies for this office. Your signature below signifies acceptance of these policies.*

**Cancellation and No Shows**

Due to the increase in late cancellations and No Call / No Shows I am forced to implement my cancellation policy. I have let it go for some time in order to be understanding disregarding the impact it has on my bottom line. Since I am self employed and this being my only source of income, I cannot afford to let it go anymore. In addition, I have a weekly waiting list which I can easily fill if given the proper amount of time.

I understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. I just ask that you give at least 24 hours’ notice. This will give me time to fill the appointment time slot. If less than 24 hours’ notice is given and I am unable to fill the slot, you will be charged a $25 late cancellation fee.

No Call / No Shows will be charged the full amount of the service you were scheduled for.

The charge will be added to your credit card on file or paid at the time of your next visit.

**Tardiness**

Due to the new extensive cleaning/sanitizing protocol, appointment times are as scheduled and cannot extend beyond the stated time to accommodate late arrivals. Please be on time to your appointment.

**Sickness**

If you are not feeling well or have been around someone who is not feeling well, whether it is COVID related or not, please cancel your appointment as soon as you are aware of any symptoms. If it is less than the required 24-hour

notice period, the cancellation fee will be waived. Please note that if this happens repeatedly you may be charged.

**COVID-19**

If you contract the COVID-19 virus you must wait 14 days after recovering before scheduling your next appointment. Any future appointments on the schedule will be cancelled for that time frame.

**No-Fault Financial Responsibility**

Once your insurance is verified, we will bill and accept payment from your insurance company for covered

services. In the event that the insurance company denies payment or makes partial payment, you are

responsible for the balance. Your signature below confirms your financial responsibility for all services regardless of insurance reimbursement. The same No Show policy rate also applies to No-Fault

**Assignment of Benefits**

Your signature below is confirmation that you have read, understand and adhere to the policies of this office.

Release of Medical Records

Your signature below authorizes the release of all of your medical records on file in this office, for the

purpose of processing your claims, to the following: your attorney, the healthcare providers attending to

this condition, and the insurance case managers. Medical records will not be edited unless otherwise

stated in an exclusive release of medical records signed through your attorney.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent for Treatment**

*To proceed with receiving care, I confirm and understand the following (Initial in all places provided)*

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World

Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be

contracted from various sources. I understand COVID-19 has a long incubation period during which

carriers of the virus may not show symptoms and still be contagious. \_\_\_\_\_\_\_\_\_\_\_\_

I understand that I am the decision maker for my health care. To the best of their ability, my practitioner

will provide me with information to assist me in making informed choices. This process is often referred to

as “informed consent” and involves my understanding and agreement regarding recommended care, and

the benefits and risks associated with the provision of health care during a pandemic. Given the current

limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is

exceptionally difficult. \_\_\_\_\_\_\_\_\_\_\_\_

I understand that preventative measures and intensified sanitation protocols intended to reduce the

spread of COVID-19 have been implemented. However, because this work involves close physical

proximity over an extended period of time in a closed space, there may be an elevated risk of disease

transmission, including COVID-19. I hereby acknowledge and assume the risk of becoming infected with

COVID-19 through this treatment and give my express permission to you and the staff at your offices to

proceed with providing care. \_\_\_\_\_\_\_\_\_\_\_\_

I have been offered a copy of this consent form. \_\_\_\_\_\_\_\_\_\_\_\_\_

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL

UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE

DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO

MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO

TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE

COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS

CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE

RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE.

I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN

THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I

SEEK CARE FROM THIS OFFICE.

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Parent or Guardian Signature (in case of a minor): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_