INFORMED CONSENT

I give Tri-Motion Rehab, LLC (TMR) consent to provide therapeutic services as ordered by my physician, or as requested by myself.

Authorization for release of information:
I certify that the information given by me is correct. TMR is authorized to furnish and release to third party agents, lawyers, and other healthcare professionals such professional and clinical information as may be necessary for the processing of medical claims. TMR is hereby released from all legal liabilities that may arise from the release of this information.

_____ **Cancellation and Lateness:**
- We realize your time is valuable, as is ours. It is therefore important to arrive promptly. Sessions begin and end at scheduled times.
- If a client does not arrive within 15 minutes of the appointed time or cancel with at least 24-hour notice, he or she will be subject to a service fee.
- Emergency cancellations are determined at the therapist's discretion (Work is not considered an emergency).

_____ **Payment and Bad Check:**
- Full payment will be collected before your session begins.
- I understand that there will be a $40.00 charge applied to my personal balance for any check that is returned to the office.

______ **Patients with Medicare- Consent to bill Medicare**
- Tri-Motion Rehab will submit claims to Medicare and Medicare supplemental insurance policy with your consent to assign benefits to Tri-Motion Rehab and allow Tri-Motion Rehab to accept payment on your behalf. Tri-Motion will bill Medicare supplemental plans, however, you are responsible for co-pays, deductibles and co-insurance.

_____ **Photograph Policy:**
- By initialing you consent that your postural photographs can be used in an educational and professional manner.

_____ **Privacy Policy:**
- Please note that email addresses and contact information will be used only to forward educational material and for professional reasons.
- All information discussed during sessions and in your chart is held in the utmost confidence.
- I have read the complete notice of privacy practice.

_____ **Authorization to speak with family members and caregivers:**
- I agree that my therapist may speak to my family members or caregivers in order to coordinate my care or to provide guidance for carryover of therapy programs.
- Therapists may **NOT** share information with : ________________________________

I have read and understand the above summary of office policies and will read the full policies in the Policy Binder.

Client's Signature: ____________________________________ Date: _______________

Responsible party's signature: ____________________________________ Relationship: _______________

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