7811 Montrose Road Suite 350
Potomac, MD 20854
301-417-8283

Consent to Treatment and Release of Information

I,_____, hereby consent to and authorize all therapy treatments, which in conjunction with the judgement of my attending physician, maybe considered necessary and/or advisable for the diagnosis and/or treatment of the patient named above at Adept Physical Therapy (Potomac Physical Therapy and Sports Medicine, LLC). I authorize Adept Physical Therapy to release information, verbal and written, contained in my medical record to my insurance company, case managers, assignees, and/or beneficiaries as it relates to my treatment and or payment.

Signature:_____ Date:_____

(PATIENT OR LEGAL GUARDIAN MUST SIGN IF PATIENT IS UNDER 18 YEARS OF AGE)

Relationship to Patient: SELF PARENT LEGAL GUARDIAN

PAYMENT GUARANTEE

I agree to pay Adept Physical Therapy (Potomac Physical Therapy and Sports Medicine, LLC) for the services provided to me. I understand and agree that the insurance claim and forms will be submitted to my insurance company and that I am responsible for all unpaid and outstanding charges regardless of my existing coverage. I also understand that I will be responsible for any deductibles, co-pays and/or coinsurances at the time of service.

Signature:_____ Date:_____

(PATIENT OR LEGAL GUARDIAN MUST SIGN IF PATIENT IS UNDER 18 YEARS OF AGE)

Relationship to Patient: SELF PARENT LEGAL GUARDIAN

APPOINTMENT POLICY

We request that you keep all of your appointments, with the exception of emergencies. If you need to re-schedule an appointment we require 24 hours notice. As soon as you are aware of a conflict with your appointment please call the office immediately.

In the instance of a cancellation without 24 hours notice or no-show to a scheduled appointment, we reserve the right to charge you a $60 fee (which is not covered by insurance).

In instances of repeated non-compliance with your scheduled visits, we also reserve the right to discontinue care and will inform your physician of the fact that your service has been discontinued due to non-compliance.

Your adherence to this policy enables us to continue to offer optimal treatment times for you and all of our clients.

Signature:_____ Date:_____

(PATIENT OR LEGAL GUARDIAN MUST SIGN IF PATIENT IS UNDER 18 YEARS OF AGE)