PATIENT INITIALS_______ CONROY ORTHOPAEDIC & SPORTS PHYSICAL THERAPY

CONSENT FORM

___AUTHORIZATION OF DIRECT PAYMENT
I hereby authorize my insurance company, ______________________________________
to release direct benefits payable for this claim to Conroy Orthopaedic and Sports Physical Therapy. I realize any expense not covered by my policy is my responsibility.

___CONSENT FOR TREATMENT AND AUTHORIZATION OF RELEASE OF RECORDS
I hereby authorize Conroy Orthopaedic and Sports Physical Therapy to conduct such examinations, administer treatment and medications as they deem necessary or advisable. I hereby authorize release of any information acquired by this office during the course of my examination and/or treatment to my employer, prospective employer, and/or insurance carrier, as required.

___POLICY ON CANCELLATION AND NO-SHOW
I realize that my failure to cancel my appointment at least 24 hours prior will result in my being charged for the failed appointment.

___NOTICE OF PRIVACY PRACTICES
I have read and understand Conroy Orthopaedic and Sports Physical Therapy notice of privacy practices.

___PERMISSION TO CONTACT OR LEAVE MESSAGES AT HOME
We recognize patient rights to have his or her health information kept private and secure, in accordance with law. At times we might find it necessary to contact you by phone for reasons including but not limited to appointment confirmation, test results, and scheduling.
I grant permission to COSPT to contact me at my home regarding information that they might need for my care/appointments. They may also leave a message with a person at my home, and/or leave a message on my voicemail. Approved phone numbers to call include:
____

Name of person legally responsible (if patient is a minor, name of parent or guardian):
____

Patient name, printed____

Patient signature____

Date____