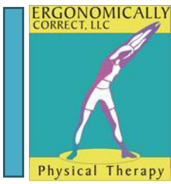


ERGONOMICALLY CORRECT, LLC
65 Old Solomon's Island Rd, Suite 104, Annapolis, Maryland 21401
Office: (410) 266-8500 * Fax: (410) 266-8520

CONSENT FOR PHYSICAL THERAPY

I give consent to this office and hereby authorize **Ergonomically Correct, LLC**, to administer such treatment as is necessary, and to perform the following therapy and/or manipulation and such additional therapy or procedures as are considered therapeutically necessary on the basis of findings during the course of said treatment.

I here by certify that I have read and fully understand the above authorization for **Physical Therapy**, the reasons why the above named is considered medically necessary, its advantages and possible complications, if any, as well as possible alternative modes of treatment, which were explained to me by the **Physical Therapist.**

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign unto Ergonomically Correct, LLC and the Physical Therapist who provides service benefits otherwise payable to me. I further understand that I will be held responsible for the payment of my account at all times regardless of insurance coverage.

CONSENT FOR TREATMENT OF MINOR OR INCAPABLE ADULT

If a patient is a minor or is incapable of giving competent, informed consent, fill out the following:

I am authorized to and do hereby give legal effective consent on behalf of the patient.

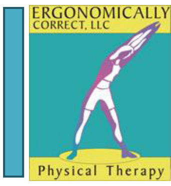
Print Name: ______________________________________ Date: ____________________

Parent/Guardian Signature: ____

THIS FORM HAS BEEN FULLY EXPLAINED TO ME AND I AM SATISFIED THAT I UNDERSTAND ITS CONTENTS AND SIGNIFICANCE.

Print Name: ______________________________________ Date: ____________________

Client/Parent/Guardian Signature: ____



ERGONOMICALLY CORRECT, LLC
65 Old Solomon's Island Rd, Suite 104, Annapolis, Maryland 21401
Office: (410) 266-8500 * Fax: (410) 266-8520

OFFICE POLICY

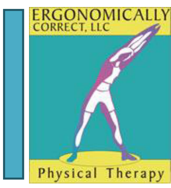
Effective October 1, 2014, the following office policy will be instituted:

1. Appointments that are missed **without** notification will result in a ***$40 missed appointment fee***.
2. We will give you every opportunity to re-schedule that appointment within on calendar week, waiving this fee.
3. If that rescheduled appointment is missed, the fee will be reinstituted.

Please complete below to acknowledge receipt of this policy.

Print Name: ____ Date: ___________________________

Signature: ____



ERGONOMICALLY CORRECT, LLC
65 Old Solomon's Island Rd, Suite 104, Annapolis, Maryland 21401
Office: (410) 266-8500 * Fax: (410) 266-8520

PRIVACY PRATICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the **Notice of Privacy Practices** and I have been provided an opportunity to review it.

Print Name: ______________________________ Birth Date: ______________

Signature: ____

Date: ______________________________