RELIANT
PHYSICAL THERAPY

Consent for Treatment:

I, the patient/guardian, acknowledge that I am of a sound mind and physically/mentally able to give consent for my care. I hereby give consent to receive outpatient physical therapy services as deemed necessary by the therapist(s) on duty at Reliant, Inc. I am aware that the practice of physical therapy is not an exact science and I acknowledge that no guarantees have been made regarding my treatments, results or outcomes. I understand that in some cases, treatment techniques may increase my pain. I understand that proper evaluation and treatment may require bodily contact, touching and/or direct contact by the therapists. I also acknowledge that as the patient/guardian I have the right to decline and/or refuse any portion of my treatment that I decide not to participate in.

Waiver and Release:

I hereby release, discharge, and acquit this facility, its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive, or allow emergency and or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician, or urgent care services.

Assignment of Benefits:

I request that payment of services be made by Medicare, third party insurance plan/payor(s), or other source as listed in my admission paperwork on my behalf to Reliant, Inc. I hereby assign all insurance and similar benefits directly to Reliant, Inc. and authorize the release of any medical records necessary to process medical claims. I understand that in the event my insurance company or financial responsible party does not pay for services or products, I will be financially responsible.

Financial Responsibility:

In consideration for services to be provided, I consent to pay Reliant, Inc. all amounts that are due or owing for services provided and not paid by Medicare, a third-party insurance plan or payor, or other source on my behalf for services so rendered. I understand that Reliant, Inc. may outsource my account to a third-party collection agency if any account balance is not in good standing or over 90 days past due.

Notice of Privacy Practices:

I hereby acknowledge that I have been offered or received a copy of Reliant, Inc.'s Notice of Privacy Practices. I understand that I may also view a copy of this document online at *www.ReliantPT.com* or request a hard copy at any time in writing to Reliant, Inc., ATTN: Privacy Director; 3825 Highway 80 East; Pearl, MS 39208.

No Show/Cancellation Fee:

In an effort to enhance each of your therapy visits, we strongly encourage regular attendance. A $20 fee may be charged for all patients who do not show for their appointment.

Release of Information:

According to office policy, medical information will be released to the patient only. Please request and complete a separate Request to Release Medical Information form to specify any third party or individual to whom information may be release to other than yourself. This information would include but not limited to medical information, billing, and other protected health information. (Example: your spouse, son, daughter, sibling, caretaker, friend)

Information Usage:

We respect your privacy and do not tolerate spam. We will never sell, rent, lease or give away your information (name, address, email, etc.) to any third party with the exception of: the payor(s) you have provided for us to send your claims to for processing, court subpoena, in compliance with relevant laws or per your written request.

By signing below, I certify that I have read and understand the statements and policies that have been stated above.

Patient/Guardian Signature: _____ **Date:** _____