Lakeshore Physical Therapy
1320 Fullerton Ave.
Chicago, IL 60614

# POLICY PAGE

## Patient Informed Consent

I have read and fully understand Lakeshore Physical Therapy's Notice of Privacy Practices.

I understand that Lakeshore Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the company in writing. I also understand that Lakeshore Physical Therapy will consider a request for restriction on a case-by-case basis, but does not have to agree with the request.

I hereby consent to the use and disclosure of my personal health information for the purposes as noted in the Notice of Privacy Policy. I understand that I retain the right to revoke this consent by notifying the company in writing at any time.

## Cancellation & No Show Policy

It is our goal to meet the needs of our patients and we will make every effort to schedule your appointments as efficiently as possible.We do realize that unanticipated events can occur and may prevent you from keeping your appointment. **If you need to cancel or reschedule your appointment, please do so at least 24 hours in advance or a $50.00 fee may be assessed.** This fee is not covered by your medical insurance.

I understand it is my responsibility to make every effort to keep my scheduled appointments and arrive promptly. I hereby acknowledge that I have read and understand the above cancellation policy and agree to abide by these guidelines.

## Patient Information Release of Authorization & Assignment of Benefits

I hereby authorize Lakeshore Physical Therapy to release to my healthcare providers and/ or my insurance company (s) any information required for the purposes of healthcare management and/ or for processing of all medical claims on my behalf. I hereby assign all medical benefits to which I am entitled to Lakeshore Physical Therapy in the event they file insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid by insurance. In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the amount owed as well as all reasonable cost associated with the collection of this debt, including but not limited to, collection service fees, attorney's fees, court costs and other fees associated with the recovery of this debt. A copy of this assignment shall be considered as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of Lakeshore Physical Therapy as may be directed by prudent medical practice by illness, injury, or condition. This consent is intended as a waiver of liability for such treatment.

☐ I certify that I have read and understand the policies outlined in this document.

Patient Name: Date: