

**PATIENT ACKNOWLEDGEMENT**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_**

**HIPAA ACKNOWLEDGEMENT-** All patients must initial one of the following**:**

\_\_\_ I hereby acknowledge that I have been provided a copy of the Notice of Privacy Practices

\_\_\_ I hereby acknowledge that I have been provided a copy of the Notice of Privacy Practices but decline to accept at this time.

Acceptable method of Contact: \_\_\_\_Home \_\_\_ Cell \_\_\_\_ Work \_\_\_\_ Email

Do you give permission for us to leave a message: \_\_\_\_\_ Yes \_\_\_\_\_ No

May we phone, email, or send a text to you to confirm appointments \_\_\_\_ Yes \_\_\_\_No

May we discuss your medical condition with any member of your family? \_\_\_\_ Yes \_\_\_\_ No

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancellation and No Show Policy

It is expected that you actively participate in the recovery process and give 100% effort towards the goals established for you, your therapist, and doctor. Your attendance is critical to the success of the program, therefore, missed appointments may be reported to your physician, insurance carrier, employer and vocational counselor. Additionally, if I fail to shop for a scheduled visit or to reschedule any visit within 24 hours prior to scheduled time, I will be charged a **$45** No Show/Cancellation fee.

\_\_\_\_\_ I hereby acknowledge that I have read and understood the above statement regarding No Show/Cancellation fee

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Covid-19 Policy Acknowledgement

\_\_\_\_\_ I hereby acknowledge that I have read and understood the practices Covid-19 policy; and to the best of my knowledge have not tested positive for Covid-19 or come in contact with someone who has in the last 2 weeks.

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I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ herein authorize Fyzical Therapy and Balance Centers of South Frederick to use, edit, copy, exhibit and distribute and use any video and/or photos of me for any lawful purposes, such as marketing and social media and for any future formats. I agree that I will not be compensated and will not receive any payments/royalties for the use of my likeness and/or have agreed to this video and/or photograph release condition without compensation. I consent that the video and/or photograph is the sole property of Fyzical Therapy and Balance Center of South Frederick. I release Fyzical Therapy and Balance Center of South Frederick from any liabilities, petitions, and cause of actions caused by me or by my heirs, executives, or any other party and will hold him/her harmless.

\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Signature) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Date)