Reliant Physical Therapy

Consent for Treatment: I voluntarily consent to receive outpatient physical therapy services as deemed necessary by the therapist(s) 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 actually 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 may withdraw my consent at any time.

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.

Authorization of Payment: 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 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: I understand that insurance coverage is not a guarantee of payment. I am responsible for any charges not covered by my insurance plan, including deductibles, copayments, and non-covered services. I authorize Reliant, Inc. to bill my insurance carrier on my behalf and to release any necessary medical information required for payment processing. I understand that I am ultimately responsible for my account balance.

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: I understand that missed appointments or late cancellations may result in a fee. I agree to provide appropriate notice when cancelling appointments.

Release of Information: Release requires written authorization except as permitted by law (payment, treatment, healthcare operations). 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 do not sell personal information.

Electronic Communication Acknowledgement: I understand that Reliant Physical Therapy may use phone, email, and electronic messaging systems to communicate regarding my care when consent is provided. I acknowledge that electronic communication may not always be fully secure.

Communication and SMS Consent: I agree to receive text messages from Reliant Physical Therapy regarding appointment reminders, scheduling updates, billing information, and care coordination. Message frequency may vary. Message and data rates may apply. Reply STOP to opt out or HELP for assistance. Consent is not required as a condition of receiving treatment. No marketing or promotional messages will be sent. Messages are transactional and related only to patient care and account management

Intramuscular Dry Needling Consent: Dry Needling may provide benefits such as decreased pain, improved muscle function, and improved mobility. Potential risks include soreness, bruising, bleeding, fatigue, pneumothorax, fainting/dizziness and in rare cases, more serious complications such as infection or injury to underlying structures. I understand my physical therapist is a licensed professional and has completed specialized training in intramuscular dry needling in accordance with applicable requirements and professional standards. I also understand that the physical therapists will not stimulate any distal or auricular points.

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

Patient Name: _____

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