



## Informed Consent

Please **initial** each section indicating your understanding of WHYoga~PT policies.

\_\_\_\_\_ **Authorization for Release of Information:**

I give WHYoga, Inc. (WHYoga~PT) consent to provide therapeutic services as ordered by my physician, or as requested by myself.

I certify that all information given by myself to WHYoga~PT is correct.

WHYoga~PT is authorized to furnish and release to third party agents and other healthcare professionals such professional and clinical information as may be necessary for the processing of medical claims. WHYoga~PT is hereby released from all legal liabilities that may arise from the release of this information.

\_\_\_\_\_ **Cancellation and Lateness:**

We request that all clients extend a courteous 24-hour cancellation notice to change or cancel any appointment.

If a client does not arrive within 15 minutes of the appointment time or cancel with at least 24-hour notice, he or she will be subject to a service fee.

Emergency cancellations are determined at the therapist's discretion (work is not considered an emergency).

\_\_\_\_\_ **Payment and Bad Checks:**

Full payment will be collected at the time of service.

I understand there will be a \$40.00 charge applied to my personal balance for any check that is returned to the office.

\_\_\_\_\_ **Insurance Reimbursement and Flexible Spending**

WHYoga~PT is **NOT** contracted with any insurance companies. Payments you make to WHYoga~PT may be reimbursable by your insurance company. In order to understand your benefits an insurance worksheet needs to be completed prior to your first visit. Please inform WHYoga~PT that you will be submitting to insurance or flexible spending at your first visit.

If you are submitting to your insurance company or flexible spending, a Doctor's prescription may be required.

WHYoga~PT will provide you with medical information necessary for you to work with your insurance company, but WHYoga~PT offers no guarantee of insurance reimbursement.

\_\_\_\_\_ **Privacy Policy**

Please note that email addresses and contact information will be used only for professional reasons.

All information discussed during sessions and in your chart is held in the utmost confidence.

I have read the complete Health Information Privacy Notice.

\_\_\_\_\_ **Authorization to speak with family members and caregivers**

I agree that my therapist may speak to my family members or caregivers in order to coordinate my care or to provide guidance for carryover of therapy program.

Therapist may NOT share information with: \_\_\_\_\_

**I have read and understand the above summary of WHYoga~PT policies.**

Client's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Responsible party's signature: \_\_\_\_\_

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