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 my self.

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. Payment should be made at time of service via cash, Venmo or check (made out to WHYoga-PT).

However, an invoice can be provided to the patient for them to submit to their Flexible Spending Account (FSA) or Health Savings Account (HSA). Please inform WHYoya~PT at initial visit.

_____ **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: _____