The Center For
BODIES IN BALANCE

1 GREENLEAF WOODS DR, STE 101, PORTSMOUTH, NH 03801
P: 603 / 319-8334 F: 603 / 431-2940

CONSENT/PRIVACY NOTICE/COMMUNICATION PREFERENCES

CONSENT FOR CARE & TREATMENT: Your Physical Therapist will complete an evaluation by examination and interview. Your individual treatment plan will be designed. A variety of techniques may be used. I, the undersigned, do hereby agree and give my consent for The Center for Bodies in Balance, LLC, to furnish physical therapy care and treatment considered necessary and proper in evaluating and/or treating my physical condition.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize The Center for Bodies in Balance, LLC, to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered.

NOTICE OF PRIVACY PRACTICES: In compliance with the Federal Law regarding patient's privacy, we ask you to read the "Notice of Privacy Practices", that is available to view at the office. I understand that I have been provided the opportunity to review this document prior to signing this consent, and that a written copy will be provided upon request.

COMMUNICATION PREFERENCES: Mark an "X" for your choice.

Best way to reach you on the day of your appointment in case we have to change or cancel your appointment?
Call Cell ____ Text Cell _____ Call Home _____ Call Work ____

Can we leave messages on your cell phone or home phone? Yes ____ No _____

Can you receive text messages? Yes ___ No ___

Do you check your email? Yes ___ No ___
If so, can we send appointment confirmations via email Yes ___ No ___

CONSENT FOR TREATMENT OF A MINOR: A parent/guardian must accompany a minor patient on all of the office visits, unless written consent of the parent or legal guardian is received.

As parent and/or legal guardian, I authorize The Center for Bodies in Balance, LLC, to treat
_____ (minor's name) while I am not present.

ALL Patients Sign Below to Acknowledge Their Understanding of the Above

_____ _____
SIGNATURE OF PATIENT/GUARDIAN/RESPONSIBLE PARTY DATE

_____
PRINT NAME

OVER