SAVOY THERAPY

Physical Therapy. Exceptional Care. Right at Home.

CONSENT FOR TREATMENT:

I Consent to a Physical Therapy evaluation and recommended follow up treatments including Home Exercise Program.

DISCLOSURE OF HEALTH CARE INFORMATION:

I agree to the release of my Physical Therapy records, inclusive of evaluation, treatment and discharge recommendations to my referring and/or primary MD, insurance and any other person/entity authorized by me to receive such information.

FINANCIAL RESPONSIBILITY:

I authorize Savoy Therapy Services Inc, including its authorized agent to bill my insurance for services rendered and I agree to be financially responsible for any co-pay and charges not covered by my insurance.

CANCELLATION POLICY:

Together, you and your therapist will set your treatment goals and time frame to complete these goals. It is important that you attend all scheduled treatment goals and time frames to complete these goals. It is important that you attend all scheduled treatment sessions to achieve the best success. If you must cancel or change an appointment, we request that you notify our office a minimum of 24 hours prior to your scheduled appointment time by calling (217) 898-8393. If you are a worker's compensation patient, please be advised that your employer, physician and rehabilitation nurse will be notified of each missed appointment.

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I acknowledge that I have received the Notice of Privacy Practices of Savoy Therapy Services Inc.

Print Name: _____ **Signature:** _____

Date: _____

Guarantor/Legal Guardian Name: _____ **Signature:** _____

Therapist Signature: _____

Therapist Name: Kishor Thope, PT, cert. MDT **Date:** _____

Savoy Therapy Services, 101 W Tomaras Ave, Suite 57, Savoy, IL 61874 | Tel: 217.898.8393 | Fax: 217.633.4553 | www.savoytherapy.com