PATIENT NAME: _____ . . _____ DOB: _____ DATE: 2/18/2021

Consent for Treatment

I hereby authorize Southern Maryland, through its appropriate therapy personnel, to perform an evaluation and treatment procedures, deemed necessary by the therapist, on me or the above named patient. This also authorizes, fabrication of a hand/upper extremity splint and serves as proof of receipt of such splint, if applicable, for myself or the above named patient.

Patient Signature: _____ Date: _____

Patient Representative: _____ Date: _____
(If patient is a minor or, if authorized by patient.)

Authorization to Release Information/Assignment of Benefits

I hereby authorize Southern Maryland to release to appropriate agencies, any information acquired in the course of my, or the above named patient's evaluation and treatment, necessary to process claims and pay Practice CAO PHYSICAL THERAPY directly for professional services rendered.

Patient Signature: _____ Date: _____

Patient Representative: _____ Date: _____
(If patient is a minor or, if authorized by patient.)

Acknowledgement of Receipt of Privacy Notice (HIPAA)

I acknowledge that I received or was offered the Notice of Privacy Practices for Southern Maryland.

Patient Signature: _____ Date: _____

Patient Representative: _____ Date: _____
(If patient is a minor or, if authorized by patient.)

Cancellation/No-show Policy

I understand that 24 hours' notice is required for cancellation of an appointment except in the event of emergency situations. If I fail to cancel two or more appointments without 24 hours' notice and/or do not show up for two or more appointments, Southern Maryland may charge me $25.00 to be paid by me, not my insurance company.

Patient Signature: _____ Date: _____

Patient Representative: _____ Date: _____
(If patient is a minor or, if authorized by patient.)