Questions about how to complete this form?
Call 206-465-5650

erin@runseattlept.com
www.runseattlept.com

Return completed form to:
106 Lakeside Ave,
Seattle, WA 98122

Consent To Treat

PATIENT NAME	DATE

By signing this form, I authorize Run Seattle Physical Therapy PLLC to provide evaluation and treatment procedures that are deemed necessary and proper in the treatment of my condition.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY	DATE

Responsibility For Payment

I understand billing my insurance is a courtesy provided to me by Run Seattle Physical Therapy, and that I am financially responsible for the remaining payment of my bill for the services provided. Co-payments are due at the time of service. I agree that Run Seattle Physical Therapy may give my insurance company, and other authorized parties, the necessary information to process claims on my behalf in a timely fashion. I authorize payment of medical benefits to Run Seattle Physical Therapy. I acknowledge that it is my responsibility to provide Run Seattle Physical Therapy with current insurance information and to familiarize myself with my insurance plan and its policies.

Cancellation / No Show Policy

I agree to provide at least 24 hours notice when I need to cancel or reschedule an appointment, and that cancellation of less than 24 hours or not showing up for an appointment will likely result in a cancel/no show charge of $75.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY	DATE

Access To and Release of Health Information

I acknowledge that I have received Run Seattle Physical Therapy's Notice of Privacy Practices and that it outlines how my health information will be used and disclosed and how I may gain access to and control my health information.

Communication

For scheduling and contact purposes, please list your preferences on different means of communication. Please check the appropriate boxes for which you authorize:

I AUTHORIZE THE RUN SEATTLE PT TO LEAVE DETAILED VOICEMAILS ON THE FOLLOWING PHONE NUMBERS	☐ Home	☐ Cell	☐ Work
I AUTHORIZE APPOINTMENT REMINDER TEXT MESSAGES TO THE CELL PHONE NUMBER PROVIDED	☐ Yes	☐ No	
I AUTHORIZE E-MAIL REMINDERS TO THE E-MAIL ADDRESS PROVIDED	☐ Yes	☐ No	

I AUTHORIZE THE FOLLOWING PERSONS TO HAVE ACCESS TO MY HEALTH INFORMATION	SIGNATURE
	DATE