Patient Information Consent Form

Consent to Physical and/or Occupational Therapy Evaluation and Treatment

I hereby consent to the evaluation and treatment of my condition by a licensed physical and/or occupational therapist employed by Sisu Therapies. The therapist will explain the nature and purposes of these procedures, evaluation, and course of treatment. The therapist will inform me of expected benefits and complications, any discomforts, and risk that may arrive, as well as alternatives to the proposed treatment and the risk and consequences of no treatment.

Patient Information Consent Form (HIPAA)

I have read and fully understand Sisu Therapies, LLC's Notice of Information Practices. I understand that Sisu Therapies, LLC. may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of service provided, and any administrative operations related to treatment or payment. I understand that I have the right to request restrictions, in writing, regarding how my personal health information is used and disclosed for treatment, payment, and administrative operations. I also understand that Sisu Therapies, LLC will consider requests for restrictions on a case by case basis but is not required to oblige to such requests.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Sisu Therapies, LLC's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time, at which point Sisu Therapies, LLC has 30 days to respond to my request.

Release of Information

I hereby authorize the release of information necessary to file claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

Designated Individuals Authorization

I, _____ hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties will be verified by photo ID before the release of any information. If none, please print "none" below.

Authorized Designees:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

I have read and understand the above consents, release of information, and designated individuals authorization above.

Patient Signature_____ Date_____

LATE CANCEL / NO SHOW POLICY

Please call our office if you cannot come to an appointment already scheduled. Please call at least 6 hours (during business hours) prior to your appointment time**.** Failure to call or show for an appointment may result in a **$30 No Show fee.**

Patient Signature_____ Date_____