ART OF HEALING PHYSICAL THERAPY, LLC
119 N. Commercial Street, Suite 1100B
Bellingham, WA 98225
360-303-8353
stacey@artofhealingphysicaltherapy.com

Informed Consent for Physical Therapy Services:

I consent to receive physical therapy evaluation and treatment services with in the scope of Physical Therapy practices from Art of Healing Physical Therapy. I understand that this evaluation and treatment is not a substitute for an evaluation from a primary care physician. It is your right to decline any part of treatment at any time before or during treatment.

Patient Name________________________ Signature_________________________ Date:________

Notice of Privacy Policies:

I understand that Art of Healing Physical Therapy, LLC will maintain my privacy to the highest standards and may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.
It is important to note that certain communications including email and text messages, which may contain your protected health information (PHI) are not invariably secure since certain communications can be intercepted, delivered and or addressed to an unintended recipient and/or improperly accessed while in storage and/or during transmission. I consent to receive notifications from Art of Healing, which may include my PHI, by the following methods of communication that I indicated below knowing the above security risks.

____ Mobile Device ___________________ Text or Voice (please circle your preference)

_____ E-mai: ___________________________

_____ Opt-out of receiving text message and email communication from Provider

Patient/ Legal Guardian Signature: ____________________________________ Date: __________

Cancelation, No Show and Late Show Policies

I understand that I may be charged $50.00 for a missed or cancelled appointment (without a 48 hour notice). If I arrive late, I will receive treatment for the remainder of my scheduled appointment time and will be responsible for the full payment of the scheduled treatment time.

Patient Signature: ____Date: ____________

Medicare/ Medicaid Policy

I understand that Art of Healing Physical Therapy has chosen not to have a relationship with Medicare or Medicaid and is unable to bill them for services rendered.

Patient Signature: ____ Date: ___________