Please initial on the line to the left of each section to show you understand and agree to the information provided.

_____ CONSENT FOR CARE AND TREATMENT

I, the undersigned, agree and give consent for In Motion Orlando, LLC to furnish medical care and treatment considered necessary. In doing so, I understand, acknowledge, and affirm that such rehabilitation and related services may involve bodily contact, touching and/or direct contact of a sensitive nature.

_____ TREATMENT OF A MINOR (IF APPLICABLE)

I, as a parent/guardian of a minor receiving treatment I agree and understand that I have been advised to remain on premises during any treatment and waive any claim I may have resulting from failure to do so.

_____ BENEFIT ASSIGNMENT/FINANCIAL POLICY

I, the undersigned, hereby assign all benefits directly to In Motion Orlando, LLC and authorized release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I received I will be financially responsible for payment. At the conclusion of my treatment, I understand that I will have **90 days** to either pay of my balance or set up a payment plan. Should my account be directed to collections, I will be responsible to pay cost of collection, including legal fees.

_____ PRIVACY PRACTICE

I, the undersigned, give my consent to obtain any medical records concerning my care from any physician, hospital or other healthcare professional that has provided care in the past. I also authorize In Motion Orlando, LLC to use and disclose my health information to any physician, hospital, or healthcare professional providing care to myself and/or my dependent(s) at any time.

I authorize the release of my Protected Health Information to the following individual(s):

_____

_____

_____ CANCELLATION AND NO-SHOW POLICY

I agree to provide at least **24 hours** notice if I am unable to attend a visit and acknowledge that if I am unable to attend this will result in a **$25 fee**. All cancellations and no shows are documented in your medical record. Case managers for worker's compensation are notified after each missed appointment.

_____ HIPAA PRIVACY ACKNOWLEDGEMENT

I acknowledge that I have been given a copy of the HIPAA Privacy Policy Notice which describes the practice's obligations to ensure the privacy of my health information. The HIPAA Privacy Notice also describes how the Practice may use and disclose my health information for treatment payment and health care operations. I know that I have the right to review the Practice's HIPAA Privacy Notice and to ask questions about it. I understand the Practice is required to maintain the privacy of my health information in accordance with the terms of its HIPAA Privacy Notice. I further acknowledge that the Practice can change its HIPAA Privacy Notice in the future and that I can receive a copy of the Practice's current Privacy Notice at any time.

Signature: _____ Printed Name: _____ Date: _____