Space Coast Lymphedema Clinic, LLC

CONSENT TO PHYSICAL/ OCCUPATIONAL THERAPY TREATMENT

I, (insert name) _____ acknowledge and understand that a therapist of Space Coast Lymphedema Clinic, LLC, has recommended that I receive treatment.

I further acknowledge that the purpose of the therapy and care, reasonable alternative forms of therapy, risks of the recommended and alternative care, and risks of foregoing this care, have been fully explained to, and understood by me.

I recognize that the practice of physical or occupational therapy is as much an art, as it is a science, and therefore acknowledge that no guaranties have been, or can be made, regarding the likelihood of success or outcome of any therapy.

I also recognize that physical or occupational therapy care may involve the touching of my body by a therapist and that partial or full disrobing may required to facilitate such care, all of which is expressly consented to me.

I agree to cooperate fully, and to participate in all physical or occupational care procedures, to comply with the plan of care as it is established, and to pay clinic charges for such care upon my receipt of clinic invoice for such care.

I have read the above and I verify that I have had an opportunity to discuss the contents thereof to my satisfaction. By signing below, I am hereby consenting to the physical/occupational therapy care described above to be performed by a therapist or other members of the SCLC, LLC professional staff, as determined by therapist from time to time.

Permission to use photographs: I grant SCLC, LLC, its representatives and employees, the right to take photographs of me in connection with the treatment that is completed during Complete Decongestive Therapy. I authorize before, during, and after treatment photos. SCLC, LLC may use, print and/or electronically download for documentation purposes as needed, and use such photographs of me with or without my name and for any lawful purpose, including for example, registration and documentation purposes.

PERMISSION GRANTED? YES_____ NO _____

Acknowledgement of Notice of Privacy Practices

Initial _____ I have reviewed a copy of SCLC's Notice of Privacy Practices. A copy of this notice is available upon my request.

PATIENT NO- SHOW AND CANCELLATION POLICY

When an appointment is scheduled, that time has been reserved for you. When it is missed or canceled with short, or no notice, that time can no longer be utilized for another patient. Our policy is as follows: You may cancel and reschedule your appointment up to ONE (1) business day before the scheduled appointment. If you miss your appointment or cancel less than ONE (1) business day before your appointment, SCLC reserves the right to bill you * 50.00 *** for each no show or late cancelation. This fee is the patient's responsibility and is not billable to insurance. We do realize that occasionally circumstances arise that are beyond your control. We will address those situations with you should they occur.**

Additionally, if a patient is more than 15 minutes late to the appointment without prior notification, we reserve the right to cancel the appointment. In this case, the cancellation fee will still apply. If you have any questions regarding this policy, please bring them to the attention of the practice manager. We thank you for working with us to ensure that we can provide the best service possible to our patients.

I have read and understand the following: Consent to Physical/Occupational Therapy Treatment

Acknowledgement of Notice of Privacy Practices
Patient No- Show and Cancellation Policy

Signature: _____ **Date:** _____