Authorization for Treatment

MUSCLES IN MOTION

1. AUTHORIZATION FOR TREATMENT: I hereby authorize **Muscles In Motion, LLC** to provide physical therapy treatment and services to myself or the named patient. I also authorize the release of such information that may be necessary for my care via mail, electronic or facsimile transmission.

2. DISCLOSURE OF HEALTH INFORMATION: I understand that **Muscles In Motion, LLC** is a health provider who must comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA protects the privacy of individually identifiable health information. The **Muscles In Motion, LLC** Notice of Privacy Practice outlines your rights and our responsibilities regarding your medical information and who to contact if you have any concerns regarding your medical information. By signing below, I acknowledge that I have been given a copy of the **Muscles In Motion, LLC** Notice of Privacy Practices.

3. CANCELLATION AND NO SHOW POLICY: With the exception of serious emergencies, it is expected that you keep all your appointments. If you need to re-schedule an appointment, we require 24 hours' notice. In such a case, please call our office and arrange for a make-up appointment with our Patient Coordinator. **In instances of repeated cancellations without 24 hours' notice or no-shows to a scheduled appointment, we reserve the right to charge you a $60 fee.**

The undersigned certifies that he/she has read the foregoing and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute this document and accept and agree to its terms. This form has been accepted.

Name Printed	Signature	Date

Signature of Parent of Guardian, if patient is under age 18	Date