PERFECT POSTURES, INC

CONSENT TO TREATMENT

ACKNOWLEDGEMENT OF INFORMED CONSENT
AUTHORIZATION TO RELEASE INFORMATION
ASSIGNMENT OF BENEFITS

1. CONSENT TO TREATMENT: I voluntarily authorize and give consent to Perfect Postures, Inc. to provide its services to me. This includes, but is not limited to, evaluation, exercise prescription and myofacial release techniques.

I acknowledge that no guarantees have been, or can be, mode to me as to the result of the services provided at Perfect Postures, Inc.
I understand that the services provided by Perfect Postures, Inc. are not a substitute for medical examination or diagnosis, and it is recommended that a physician be consulted for that service.

2. ACKNOWLEDGMENT OF INFORMED CONSENT: I understand that I will be informed of the potential risks and benefits of all services provided by Perfect Postures, Inc.

I understand that I have the right to consent, or to refuse consent, to any procedure or service offered by Perfect Postures, Inc..

3. AUTHORIZATION TO RELEASE INFORMATION: I authorize the release of any information contained in my Perfect Postures, Inc records for:

a. assist in processing my insurance claims
b. provide information to my referral source,
c. provide information to my personal physician.

4. ASSIGNMENT OF BENEFITS: I understand that payment for services provided by Perfect Postures, Inc. will be made at the time services are rendered or in advance of services rendered by agreement, unless, other financial arrangements are made in advance.
Perfect Postures, Inc. will not bill your insurance company directly. As a service, we will provide you with any forms or information required to help you process your claim for reimbursement.

I understand that liens and settlements are NOT accepted by Perfect Postures, Inc

(initial) 5. CANCELLATION POLICY: I understand that Perfect Postures, Inc. requires a minimum of 24 hours notice for any cancelled appointment. This is necessary to meet the needs of our clients and to provide the best possible service. I understand that a $25.00 fee will be charged to me for the first cancellation that occur with less than 24-hour notice and for the first "no-show" or missed appointment. I also understand any future occurrence will be the cost of a full appointment.

(initial) 6. PREPAYMENT FOR 6 SESSION PACKAGE: I understand upon completion of the 2nd visit that there will be no refund for the remaining balance. However, Perfect Postures, Inc. will honor the remaining visits for up to one year from the date of purchase.

Signature:

Date:

Parent / Guardian: (if a minor)

Date:

I authorize the release of any information contained in my Perfect Postures, Inc. records

A photocopy of this form shall be considered as valid as the original.