SAVOY THERAPY

1907 W.Springfield Ave, Suite B
Champaign, IL 61821
Tel: (217) 898-8393

CONSENT TO TREATMENT :

_____Consent: I consent to and authorize Savoy Physical Therapy to administer Physical Therapy evaluation, treatment under the direction and supervision of the Physical Therapist and Physical Therapy Licensed Assistant. I understand and am informed that, as in the practice of medicine, Physical Therapy may have some risks. I understand that I have the right to ask about these risks and have any questions about my conditions answered prior to the start of treatment.

____Marketing Consent: I agree to sharing my treatment experience with Savoy Therapy in their newsletter, website, social media posts and other distribution platforms using written testimonials, photos and/or videos.

____Financial Responsibility: I authorize Savoy Therapy Services Inc, including its authorized agent to bill my insurance for services rendered and I agree to be financially responsible for any co-pay and charges not covered by my insurance.

Medicare will pay	Secondary Insurance will pay	Private Insurance will pay	Your copay	Private Pay

____Cancellation/No Show Policy: Together, you and your therapist will set your treatment goals and time frame to complete these goals. It is important that you attend all scheduled treatment within appropriate time frames to complete these goals and achieve success. If you must cancel or change an appointment, we request that you notify our office a minimum of 24 hours prior to your scheduled appointment time by calling (217) 898 - 8393. If you are a worker's compensation patient, please be advised that your employer, physician , caseworker or rehabilitation nurse will be notified of each missed appointment.

____Release of Information: Savoy Physical Therapy releases patient healthcare information for purposes of treatment or payment, or to other healthcare organizations, as explained in our HIPAA Notice of Privacy practices. I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.

____Receipt of Notice of Privacy practices: I acknowledge that I have received the Notice of Privacy Practices of Savoy Therapy Services Inc.

The undersigned patient or Responsible Party acknowledges that he/she has read and agreed to the information printed above.

Patient/Responsible Party Name :_____

Patient/Responsible Party Signature :_____ Date:_____

Savoy Therapy Witness Signature :_____ Date :_____