**PATIENT CONSENT FORM**

**BEND & STRETCH**
**Pilates | Physical Therapy**
***Kateryna Bakay, PT, MPT, OCS***

4250 8TH Ave NW, Suite 100
Seattle, WA 98107
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E: bakaykat@hotmail.com

Name: (First) _____ (Middle Initial) _____

(Last) _____

***TERMS & CONDITIONS – please initial***

_____ I (or my dependent) have insurance coverage and assign directly to Bend & Stretch all insurance benefits, if any, otherwise payable to me for services rendered. I understand there may be services provided and/or recommended by my provider that my insurance company may identify as noncovered services. I am financially responsible for all charges whether or not paid for by insurance.

_____I hereby authorize Bend & Stretch practitioner to release all information necessary to secure the payment of benefits and by signing below I authorize all insurance submissions. I understand that co-payments are due at the time of service.

_____ I hereby give my consent for Bend & Stretch to use and disclose my protected health information (PHI) to carry out treatment, payment, and healthcare operations. I have been informed of my rights to privacy regarding my PHI under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

_____With my consent, Bend & Stretch may call, email, or mail to my home or other alternative location in reference to any items that assist in carrying out treatment, payment, or health care operations, such as appointment reminders, insurance items and any information pertaining to my clinical care.

_____Bend & Stretch keeps a record of the health care services provided to you. You may ask to see and copy that record. Bend & Stretch will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so.

_____I give permission for the following individuals to request and discuss treatment or account information regarding my medical care:

_____

____ I authorize Bend & Stretch to mail, email, or cax the following information to the address, email address of fax number, per my request *(Optional)* to the following business/individual:

_____

_____I understand that Bend & Stretch has a **24-hour cancellation policy** and that a **charge of $50** will be billed to me directly if I miss any appointment or fail to provide the required 24-hr notice when cancelling an appointment. I further understand that arriving late to a scheduled appointment may result in a shortened or rescheduled appointment. I realize that emergency do occur – late cancellation due to illness or family emergency won't be billed. You may call or text tat 918-688-4403 or email at bakaykat@hotmail.com to cancel or reschedule your appointment.

____ I understand that initial evaluation and subsequent visits last approximately 55mins. Fees fluctuate depending on the procedure performed. Interest fees are applied to patient account exceeding 30days past due. Patients are seen by appointment only and scheduling is based on a first come, first served basis on-line through Bodycenter studios website, in person with me or your Bodycenter Studios Pilates instructor, or by phone at 918—688-4403.

_____I certify that the information provided on this form is true and correct to the best of my knowledge. I give permission for the Bend & Stretch practitioner to administer and perform such procedures as may be deemed necessary for treatment. By initialing above and signing below, I am indicating that I understand and agree to the above terms and conditions.

Patient Signature: _____ Date: _____

Parent/Guardian (if patient is under age of 18) _____Date: _____