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Phone: 808.734.0010 • Fax: 808.734.0013

CONSENT FOR CARE AND TREATMENT

I, _____, do hereby agree and give my consent to Gesik Physical Therapy to furnish medical care and treatment considered necessary and proper in treating my physician's diagnosed physical condition.

_____ **I understand that I am opting for physical therapy treatment and the potential risks associated with receiving treatment during the COVID-19 pandemic. Despite all safety protocols of the office, I understand my treatment is person-to-person contact, in which COVID-19 can be transmitted.**

_____ **I agree to notify the office if I have recently travelled, been exposed to someone who has recently took a COVID-19 test or a person who tested positive for COVID-19, or if I have any remote symptoms. I acknowledge the information above on addressing the COVID-19 pandemic and elect to proceed with my desired physical therapy treatments at this time.**

I hereby assign all medical benefits for treatment provided in the clinic to which I am entitled, including Medicare, private insurance, worker's compensation insurance, motor vehicle insurance, and other third party payers to Gesik Physical Therapy. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize the clinic to release all information necessary including medical records, to secure payments.

As a courtesy, Gesik Physical Therapy will attempt to verify your health insurance benefits and eligibility. **All in-office co-pays are an estimate of the patient's responsibility. You may have an annual deductible that you have to meet before your insurance is able to make payments. It is your responsibility to know your annual deductible, as it may change on a day to day basis depending where you are receiving care.** You will be responsible for the remaining amount after the insurance has paid. The clinic will bill your insurance carrier for you, provided we have complete insurance information at the time of the visits. **Questions regarding your benefits should be directed to your insurance carrier.**

I agree to give at least **24-hour** notice for all cancellations and rescheduling of appointments. I understand that failure to give proper notification may result in a fee of $40.00 and/or suspension of services.

DATE: _____

I, X_____, declare that I have read and understand the above information and am responsible for the payment of my account in a timely manner.