Sacramento Myofascial Release

Consent To Treatment

CONSENT TO TREATMENT: I hereby request and give my consent to Jocelyn Littlejohn, PT (dba Sacramento Myofasical Release) to provide Physical Therapy and Myofascial Release treatment for myself or on behalf of the patient. I understand that the purpose of this program is to enhance my overall health and well-being. Treatment may include manual hands-on bodywork, exercises, and posture retraining and balance activities. I have been informed that Myofascial Release areatment will not cause injury but I may experience discomfort following exercises, stretching and manual techniques done to muscles and connective tissue. I understand, as with all Physical Therapy and medical treatment, that there is no guarantee that the proposed course of treatment and the risks and benefits of those interventions will be reviewed with me at that time. I understand I may decline the use of any interventions offered.

FINANCIAL AGREEMENT: I understand Jocelyn Littlejohn, PT/Sacramento Myofascial Release is not contracted with insurance companies. I agree for myself, or on behalf of the patient, to fully pay all charges for services and supplies provided by Jocelyn Littlejohn, PT/Sacramento Myofascial Release on the day they are received. If I choose to use my health insurance benefits for my treatments, I understand it is my responsibility to submit my claims and paperwork to my insurance company. If my health insurance policy has special requirements or preauthorization required for reimbursement, I understand that I am responsible for meeting those requirements. 24-hour notice is required for cancellation of any appointment at no charge. If I "no show" or cancel with less than 24-hour notice, I am responsible for a one-hour session fee.

AUTHORIZATION FOR RELEASE OF INFORMATION: I I authorize Jocelyn Littlejohn, PT/Sacramento Myofascial Release to disclose treatments and treatment progress when requested by me, to the extent necessary for me to obtain reimbursement from: my private health insurance company, auto insurance, worker's compensation and employer. When requested by me, I give my consent for disclosere of information concerning my treatments, procedures and treatment progress to my Family Physician or Referring Physician. I understand that Jocelyn Littlejohn, PT/Sacramento Myofascial Release will protect the confidentiality of my medical information, but I release Jocelyn Littlejohn, PT/Sacramento Myofascial Release from liability when responding in good faith to an apparently valid request for informationon. This release my not be revoked for any record relating to services provided except by written notice submitted to Jocelyn Littlejohn, PT/ Sacramento Myofascial Release.

If I have provided Jocelyn Littlejohn, PT/Sacramento Myofascial Release with my home phone and/or cell phone number or email address, I give consent for her to contact me and leave email, text, and/or voice messages regarding questions or arrangement concerning my treatment and appointments.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES: By signing below, I acknowledge that I have received a copy of Jocelyn Littlejohn, PT/Sacramento Myofascial Release Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that Jocelyn Littlejohn, PT/ Sacramento Myofascial Release keeps my medical records in a secure, non-electronic format (written) and I consent to have records stored in this system. I have the right to inspect my information and receive and accounting of disclosures.

By signing below, I certify that I have read and understand this form and accept its terms and conditions, and that I am signing as a patient or as patient's authorized representative.

_____ _____

PATIENT SIGNATURE-REPRESENTATIVE SIGNATURE DATE

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PATIENT'S NAME