Cancellation Policy

I agree to a minimum of 24 hours notice of cancellation for appointments. I understand that I will be charged **$25.00** for missed appointments without the minimum notification.

Signature____ Date__________________

Financial Policy

I understand that if I am using insurance, claims will be filed for me, but I am responsible for making my insurance copayment and/or deductible at the time of service. I further agree that if, for any reason, my medical insurance does not fully cover the entire expense, I am responsible for the remaining balance.

Signature____ Date__________________

Consent to Treatment and Confidentiality Statement

I, ____, consent for treatment for therapy for (client name)_____________________________________ by Jake Wear MA,PT or one of his associates. I grant authority to him to perform those procedures and treatments, necessary for my condition and that are generally used in this and similar settings.

I understand that information or opinions will be given to others only with my written consent.

Client Signature______________________________________Date_______________________

Parent or Guardian Signature____

Signature for HIPAA Compliance

I acknowledge that I have received and/or been given opportunity to read copy of Privacy Practices. I understand that if I have any questions, I can ask my therapist for clarification.

Signature____ Date____________________