APT VIRGINIA

Consent for Release of Medical Information

I hereby authorize APT Virginia to release medical information contained in my/ the patient's records to any necessary insurance carrier(s) and/or employer(s) and/or organization(s), for the purpose of obtaining information and/or reviewing the record of medical care received by the patient and for the payment of all medical charges. Copies of the records may also be sent to referring physician(s) at the request of the Physicians treating me/ the patient. Unless noted below, medical records released may also include diagnostic and therapeutic information. Withhold from release:

Please specify, if any: _____

Patient's Name: _____ Parent/ Legal Guardian Signature: _____ Date: _____

Consent for Treatment in a Group Setting

APT Virginia in compliance with Federal HIPPA Regulations is committed to protecting our patient's health information and privacy. Our providers and staff will be making every effort to ensure that your protected Health Information is kept private. However, due to the nature of the open setting of our treatment areas, your treatment may be performed in the presence of other individuals. In some instances, it is possible that other patients and staff will overhear information relating to your treatment, diagnosis and insurance benefits.

By signing this consent, you are consenting to the disclosure of your protected health information to any other individuals who may be present in the therapy area. By signing below, I acknowledge and agree to the above conditions.

Patient/ Legal Guardian Signature: _____ Date: _____

Consent for Treatment of a Minor

As a parent and/or legal guardian, I authorize APT Virginia to treat the minor patient named in the attached forms while I am not present.

Patient's Name: _____ Parent/ Legal Guardian Signature: _____ Date: _____

No Show/ Cancellations

We realize circumstances might cause you to miss a scheduled appointment; however, to provide the best care and service to each patient, we ask that you notify us 24 hours in advance to cancel your appointment. We will be more than willing to reschedule your appointment for a different time on the scheduled day OR within 24 hours. Please be aware that failure of proper notification could result in a No Show/Cancellation fee of $25. We value our patient/provider relationships and will do everything we can to accommodate you. Your communication and compliance are not only very much appreciated but will help you (and others) achieve a positive outcome.

Patient/ Legal Guardian Signature: _____ Date: _____