



INFORMED CONSENT

www.naturalbalancetherapy.com

I give Natural Balance Therapy, LLC (NBT) consent to provide therapeutic services as ordered by my physician, or as requested by myself.

Authorization for release of information:

I certify that the information given by me is correct. NBT is authorized to furnish and release to third party agents, lawyers, and other healthcare professionals such professional and clinical information as may be necessary for the processing of medical claims. NBT is hereby released from all legal liabilities that may arise from the release of this information.

Summary of Policies: Please view full policies in Policy Binder

_____ **Cancellation and Lateness:**

- We realize your time is valuable, as is ours. It is therefore important to arrive promptly. Sessions begin and end at scheduled times. If a client does not arrive within 15 minutes of the appointed time or cancel with at least 24-hour notice, he or she may be subject to a service fee. Emergency cancellations are determined at the therapist's discretion (Work is not considered an emergency).

_____ **Payment and Bad Check:**

- Full payment will be collected before your session begins.
- I understand that there will be a \$40.00 charge applied to my personal balance for any check that is returned to the office.

_____ **Insurance Reimbursement and Flexible Spending:**

- Please let your therapist know if you will be submitting to insurance or flexible spending at your first visit. We do not bill insurance companies or submit to flexible spending directly, but will assist you with the process. If you are submitting to your insurance company or flexible spending a Doctor's prescription is required (we have orders that you can take to your Doctor to sign). Information you need to submit to your insurance company will be provided as you request it.

_____ **Photograph Policy:**

- By initialing you consent that your postural photographs can be used in an educational and professional manner (pictures will not be shared and are for educational purposes between therapist and client).

_____ **Privacy Policy:**

- Please note that email addresses and contact information will be used only to forward educational material and for professional reasons.
- All information discussed during sessions and in your chart is held in the utmost confidence.
- I have read the complete notice of privacy practice.

_____ **Authorization to speak with family members and caregivers:**

- I agree that my therapist may speak to my family members or caregivers in order to coordinate my care or to provide guidance for carryover of therapy programs.
- Therapists may **NOT** share information with : _____

I have read and understand the above summary of office policies and will read the full policies in the Policy Binder.

Client's Signature: _____

Date: _____

Responsible party's signature: _____

Relationship: _____