Therapy Treatment Consent Form
Private Pay Client

Patient Name: _____ **Date of Birth:** _____

- ☐ **Occupational Therapy**
- ☐ **Physical Therapy**
- ☐ **Speech Therapy**

It is important that you understand the purpose and need for therapy. If you have any questions regarding this therapy, please feel free to consult your evaluating therapist(s), or you may call your physician.

I authorize Stellar Rehabilitation, LLC to provide therapy services according to the proposed plan of care provided by the evaluating therapist(s). I agree to the use of personal information with regards to my therapy treatment and plan of care provided by Stellar Rehabilitation, LLC. I further authorize the sharing of information with my physician(s) and insurance company(s) when appropriate for determining treatment, eligibility, and coverage for therapy services provided.

I understand that I will be responsible for the cost of services at a rate of $75.00 per visit for a therapist's appointment and $60.00 per visit for an assistant's appointment (only available for PT and OT). Cancellations less than 24 hours before appointment time will result in a missed visit charge, which will be half of the therapist's rate. Rehabilitation, LLC will send monthly invoices to the address below for all therapy services provided. Payments can be made by cash, card, or check.

_____
Print Name of Responsible Party (Patient/Parent/Guardian)

_____ _____
Signature **Date**

□ I would like to receive text reminders for my appointments the day before my appointment.
***Standard text messaging rates may apply.**

Billing Information

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone Number: _____