Professional Sports & Orthopaedic Rehabilitation Associates, LLC
dba Game Shape Physical Therapy
455 Route 9 South, Manalapan, NJ 07726
Office: (732) 617-8090
Fax: (732) 972-5458
Email: info@GameShapeOnline.com
www.GameShapeOnline.com

IMPORTANT PATIENT INFORMATION AND AGREEMENTS

*(Please Read, Initial, and Sign **ALL AREAS Marked!**)*

INSURANCE COVERAGE AND FINANCIAL RESPONSIBILITY

Game Shape Physical Therapy appreciates the confidence you have shown in choosing us to provide for your rehabilitative needs. At Game Shape Physical Therapy, "service" is our business. We are committed to serving you with skill, knowledge and care. We consider health care to be a team effort between the patient, the physician, and us. It is a service that you have elected to participate in, which implies a financial responsibility on your part to Game Shape Physical Therapy. It is a responsibility that requires you to ensure payment in full of our fees.

It is our goal to provide our patients with the best quality of rehabilitative care at a reasonable cost, while still providing full service, such as billing directly to your insurance carrier on your behalf. In today's health care marketplace, coverage for physical therapy varies greatly with the type of insurance you have. Many insurance companies require precertification for physical therapy. Prior to your first visit we will call your insurance company to ascertain your particular insurance coverage and/or requirements. We will advise you of this information before you start therapy, and we will make every effort to comply with your insurance company's requirements to ensure proper coverage. For your benefit, an explanation of insurance coverage is provided below. We participate with most insurance plans.

Costs to expect if you are using: *(Front Desk - Check One)*

_____ **Workman's Compensation as your coverage:**
If you were injured at work and filed a claim with your employer, your employer's workman's compensation insurance company will pay the entire amount of your care and we will bill them directly for your physical therapy. All workman's compensation plans are accepted by Professional Sports & Orthopaedic Rehabilitation Associates, LLC, dba Game Shape Physical Therapy with employer authorization.

_____ **Automobile - Personal Injury Protection (PIP) as your primary coverage:**
Every NJ auto policy has a deductible and a co-payment amount, which is typically 20%. Beyond that, we will bill your insurance company directly and wait for their payment. For example, a typical policy may have a $250 deductible and a 20% co-payment for the first $5,000 of care. Therefore, you would be responsible for all of the first $250, and 20% of the next $5,000. After that, most are covered 100% to the maximum coverage of your policy (usually $250,000). When purchasing your auto policy, you may have selected this arrangement or different coverage amounts. Check your policy or call your insurance agent for the details of your coverage and call us if you have any questions. All auto plans are accepted by Professional Sports & Orthopaedic Rehabilitation Associates, LLC, dba Game Shape Physical Therapy.

Additionally, if you so elected when purchasing your auto insurance coverage, your health insurance or Medicare policy may act as a secondary insurer and pay your deductible and copayment amounts. Again, check your policy or call your insurance agent for details of your coverage and call us if you have any other questions.

_____ **Medicare as your primary coverage:**
We are participating providers with Medicare and will bill Medicare directly for you. You are responsible for the Part B deductible (**2022 is $233)** and the 20% co-payment. Professional Sports & Orthopaedic Rehabilitation Associates, LLC agrees to accept the Medicare fee schedule and wait for payment. If you have a secondary insurance (Medicare supplement or other indemnity plan), we will bill them for the 20% and wait for their payment. If not, you are responsible for the 20% co-payment. **Effective January 1, 2022, Medicare and related secondary insurance plans will restrict basic physical therapy coverage to $2,150 per year. After $2,150 has been met you will likely qualify for additional care based on medical necessity. If your case is medically necessary, we will add a modifier to your billing and obtain a higher benefit of $3,000. (This will be approximately 25-30 visits per calendar year).** Beyond that, if your care is absolutely medically necessary, we can provide you with additional services, but we may incur a Medicare Audit. If Medicare determines that care was NOT medically necessary, then you will be responsible for the daily rate of $115 per visit. Likewise, if we deem your care NOT medically necessary, after the $3,000 amount is reached, then you will have an option to self-pay at $115 per visit, or seek PT services at a local hospital or other facility that will accept Medicare after that point. **Refer to your ABN Notice.** Some exceptions may apply. See staff for details.

_____ **PPO Health Insurance as your primary coverage:**
Expect to pay any remaining amount of your annual deductible and the amount of your co-payment ($) or co-insurance (%). The rest, we will bill to your insurance company and wait for their payment directly to us.
Please Note: If you have a **secondary private insurance plan** available through the coverage of your spouse, Professional Sports & Orthopaedic Rehabilitation Associates, LLC, dba Game Shape Physical Therapy is able to bill that insurance for the co-payment amount. ***Please let us know ahead of time if you have secondary insurance.***

_____ **HMO / POS Health Insurance as your primary coverage:**
Feel free to call us and / or your insurance representative to find out if we participate with your insurance plan. In addition, we will verify your specific coverage. You are responsible for your deductible and your daily copayment amount. When receiving care within your network, you may need a referral from your primary care doctor, before seeing us. Ex. Amerihealth HMO, Aetna (occasionally required).

_____ **No Insurance Coverage / Self-Pay Option:**
In this case, there is no insurance coverage available for you to receive services rendered at Professional Sports & Orthopaedic Rehabilitation Associates, LLC. Therefore, you agree to self-pay at the rates determined and outlined to you by: Game Shape Physical Therapy. Initial Evaluation: $175. Regular PT Visit: $115 each.

<u>Disclaimer:</u>

We always recommend that patients call their own insurance company to make sure that the information we were given during the insurance verification process was correct. Patients are responsible for the "correct" amount due, and not necessarily what was told to us on the phone during the verification process.

Some insurance companies also require a "Referral" from your primary care doctor before seeing

us. Patients are responsible to know if their insurance plan requires such a referral form.

Treatments rendered without the proper "referral" (if required) will be the responsibility of the patient. In addition, we will verify your specific coverage. If Game Shape Physical Therapy is an in-network provider you are responsible only for in-network co-payments and any deductible listed on your insurance card. If we are not a participating provider, you are responsible for out-of-network copayments and deductibles listed on your insurance card.

Please feel free to call us for advice regarding details of coverage for your situation.

We are listed in "provider handbooks" under the name of either:

1). Clinic Name: Professional Sports & Orthopaedic Rehabilitation Associates, LLC, dba Game Shape Physical Therapy ****Our Clinic NPI is: 1497894968**

2). Dr. Michelle E. Wolpov, PT, DPT, MBA, ATC, CSCS **License #: 40QA00391100**
Individual NPI: 1083769889

3). Dr. John Murray, PT, DPT **License #: 40QA0189**
Individual NPI: 1698315426

4). Dr. Robert Gluck, PT, DPT **License #: 40QA01932500**
Individual NPI: 1619588597

4). Dr. Patrizia Tolentino, PT, DPT **License #: 40QA02014100**
Individual NPI: 1417520925

We also know that insurance plans and payments are increasingly complex for our patients. We want you to understand your benefits and the financial arrangements for paying for the cost of your care. We will provide you a list of health insurers with which we are in-network, including Medicare. We do accept out-of-network benefits for all other insurance plans. These out-of-network benefits are different than if you received services from an in-network provider. Your insurance plan may require multiple copays, higher deductibles, and coinsurance. Coverage will depend on the type of plan you have chosen. The amount, or estimated amount, that we will bill you for our services is available to you upon request and will be explained to you prior to providing services.

Financial Responsibility

As used below, "you" and "your" mean the patient/person financially responsible for payment for the patient's care.

Although you are responsible for the entire bill when the services are rendered, it is our policy to bill your insurance carrier or other provider of medical benefits as a courtesy to you. While we will make a good faith attempt to verify your benefits prior to the first appointment, this is no guarantee that our services will be completely covered. You are responsible for understanding the details of your health insurance coverage, as well as fulfilling any requirements for coverage, such as pre-authorizations. Required co-payments and

estimated coinsurances are to be made as services are rendered. Arrangements are to be made for payment of all amounts not covered by your medical benefits or estimated co-insurances as soon as those amounts are known.

If any payments of medical benefits are made directly to you for services rendered by Professional Sports & Orthopaedic Rehabilitation Associates, LLC, dba Game Shape Physical Therapy, , you must remit such payment directly to Professional Sports & Orthopaedic Rehabilitation Associates, LLC, dba Game Shape Physical Therapy within ten (10) days of receipt. We will ask you to sign an Assignment of Benefits authorizing us to receive payments from your health plan for the services we rendered to you.

I have read the above policy regarding my financial responsibility to Game Shape Physical Therapy for providing rehabilitative services to me or the individual named below. I agree to pay Game Shape Physical Therapy the full and entire amount of all bills incurred by me or the individual named below; or any amount due after payment has been made by my insurance carrier. **Initial Here_____**

If you are a Workers' Compensation patient the above policy does not apply to you. Be advised, however, that you may be responsible for the total amount of your charges if your Workers' Compensation claim is denied.

As a service to you, we will keep a copy of your insurance card on file and will submit an insurance claim on your behalf to your insurance company with the information you have provided us. You must provide accurate information and any updates to your insurance information. Payment options at the time of service include cash, check, or credit card. With your authorization, we will charge an approved credit card for the patient balance as determined by the insurance company once we have submitted a claim and received the Explanation of Benefits.

I understand that it is my full responsibility to inform Game Shape Physical Therapy of any correspondence that I receive from my insurance company notifying me of a change or cessation of payment of physical therapy bills. **Initial Here_____**

Physical therapy benefits are quoted to Game Shape Physical Therapy by my insurance carrier. These benefits are subject to the terms and conditions of my plan and are NOT necessarily a guarantee of payment.

We understand that choosing a health care provider is an important decision and we appreciate you choosing Professional Sports & Orthopaedic Rehabilitation Associates, LLC, dba Game Shape Physical Therapy. We are happy to explain our services, our financial policies, and the fees for our services, or the basis for determining the fees to be charged, and answer any questions you may have. We will provide a list of our current fees for standard services, upon request.

We do not charge a fee for preparing an insurance claim form on your behalf. We will charge a missed appointment fee if you fail to notify us at least 24 hours in advance of your scheduled appointment.

If your health insurance company denies payment, for any reason, the balance will be due in full from you. If you fail to make timely payment for any amount for which you are responsible, you will be responsible for all costs of collection, including court costs, collection agency fees, and reasonable attorney fees, as allowed by law. **Initial Here_____**

Financial hardship should never stand in the way of needed services. A determination of financial hardship can only be made on a case-by-case basis, in compliance with all of the rules applicable to our practice. Upon obtaining necessary information from you, we can make a good faith determination as to whether your circumstances constitute a financial hardship and what payment plan options you may have, including installment payments. Please speak to our patient advocate if you have any questions about our

financial hardship policy.

Patient Financial Agreement:

I verify that my insurance plan coverage has been explained to me. I have been informed if any of the services rendered to me by Professional Sports & Orthopaedic Rehabilitation Associates, LLC, dba Game Shape Physical Therapy will be reimbursed at an out-of-network level. I knowingly, voluntarily and specifically select Game Shape Physical Therapy as my provider. I have read the above information and I understand and accept the terms and conditions of the above and I or my Guarantor will be responsible for the payment of my account.

Please circle one: Patient / Guardian / Guarantor

PRINT Patient Name: _____

Patient's Social Security Number (for Benefits Verification & Billing use only): _____

Signature: _____ **Date:** _____

If different:

PRINT Guardian/Guarantor Name:_____

Guarantor's Social Security Number (for Benefits Verification & Billing use only): _____

Signature: _____ **Date:** _____

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION

By completing this form, you will help ensure payment to Professional Sports & Orthopaedic Rehabilitation Associates, LLC, dba Game Shape Physical Therapy ("PSORA") for services under your health insurance policy or benefit plan.

I hereby assign to ("PSORA") my right to receive reimbursement for health care services provided to me and/or to any beneficiary under my health benefits plan and assign my legal claim to benefits under the plan, including but not limited to, my right to appeal and sue for such reimbursement and benefits. This assignment applies to all medical benefits, i.e., Medicare, private insurance, major medical benefits, Workers' Compensation and any other health plans to which I or my beneficiary am entitled. I hereby authorize "PSORA" to file claims with all such plans and carriers for services rendered to me and/or my beneficiary and further authorize and direct my insurance benefits to be paid directly to"PSORA". I understand and agree that, if a reimbursement check is made payable to "PSORA"and me, that I promptly will take such action as requested by "PSORA" to endorse the check so that "PSORA" can be paid for services rendered.

I understand that I am financially responsible for payment for all services rendered and I agree to pay all charges denied or not covered by my insurance carrier. This assignment and authorization in no way releases me from this responsibility and imposes no obligation on "PSORA" to collect money on my behalf.

Initial Here_____

I hereby authorize "PSORA" to release to my insurer, health plan and/or any authorized employee or agent of the same such of my medical information and records necessary to secure payment for services rendered.

In addition,

- I authorize my insurance company to pay benefits directly to Professional Sports & Orthopaedic Rehabilitation Associates, LLC, dba Game Shape Physical Therapy
- I am financially responsible for any non-covered services provided by Professional Sports & Orthopaedic Rehabilitation Associates, LLC, dba Game Shape Physical Therapy. This pertains to any denial for payment by my insurance carrier.
- I authorize Professional Sports & Orthopaedic Rehabilitation Associates, LLC dba, Game Shape Physical Therapy to release medical information required for billing purposes.
- I understand that the bill for any scheduled physical therapy appointments not cancelled at least 24 hours prior, excluding any personal emergencies or situations approved by my treating therapist, shall be paid for by me.

I have read, understand and agree to the above. A photocopy of this agreement shall be considered as effective and valid as the original. This Assignment of Benefits will be effective until revoked by me in writing. Any revocation shall have a prospective effect only.

Please circle one: Patient / Guardian / Guarantor

PRINT Patient Name: _____

Signature: _____ **Date:** _____

If different:

PRINT Guardian/Guarantor Name:_____

Signature: _____ **Date:** _____

NOTICE OF PRIVACY PRACTICE

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

Effective Date of this Notice January 1, 2022

I have read and understand the Notice of Privacy Practice.

Please circle one: Patient / Guardian / Guarantor

PRINT Patient Name: _____

Signature: _____ **Date:** _____

If different:

PRINT Guardian/Guarantor Name:_____

Signature: _____ **Date:** _____

COMMUNICATION PREFERENCES

Patient Name (please print): _____ DOB: _____

NOTE: ***An email is necessary for us to deliver your home exercise program. A Cell Number is necessary for Text Appointment Reminders.***

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail: _____
Please note, if you supply a cell phone number and/or an email address, you will receive appointment reminders through these methods. You may later opt-out of them if you wish.

What is your preferred communication method? Email _____ Phone_____ Text _____

In Case of Emergency: _____ **Phone:** _____

In regards to messages left on voicemail or an answering machine, you authorize your doctor or staff: (please choose one):

_____To leave messages regarding your medical condition(s), as well as appointment reminders, billing/financial questions, and requests to call the office.

_____ To leave only messages regarding appointment reminders and requests to call the office. Do not reference your medical condition(s) in the message.

In addition, you may authorize us to contact a family member regarding your medical care or financial matters. This is to acknowledge that you authorize "PSORA" to disclose your PHI to the following individuals:

Name: _____ Relationship to Patient: _____
Telephone: ( ) _____ Email: _____

Name: _____ Relationship to Patient: _____
Telephone: ( ) _____ Email: _____

Name: _____ Relationship to Patient: _____
Telephone: ( ) _____ Email: _____

Authorization
The above information has been approved by the patient and/or their representative. I understand I may notify the doctor's office at any time of changes to this consent, which would require a new form and authorization to be completed. I understand that during the transmission of text/email messages, the information contained at one point or another may pass through a public network, onto a personal electronic device and as such the transmission may not be secure.

By submitting this information, I confirm that I am only acting for my own email account, or one for which I have express authority to submit this request. Once the subscription is confirmed, I agree to accept newsletter and home exercise program emails from "PSORA" and my email address will not be used for any other purpose. I understand that I may unsubscribe at any time by following your instructions and that I may still receive a limited number of emails while this request is processed. "PSORA" will NOT share, distribute, or sell your email address.

Please circle one: Patient / Guardian / Guarantor

PRINT Patient Name: _____

Signature: _____ **Date:** _____

If different:

PRINT Guardian/Guarantor Name:_____

Signature: _____ **Date:** _____

CONSENT TO TREATMENT

I understand that I have been referred for rehabilitative treatment and care to Professional Sports & Orthopaedic Rehabilitation Associates, LLC, dba Game Shape Physical Therapy. A therapist representing Game Shape Physical Therapy will describe for me my individual treatment plan. I understand that I have the right to ask and have my questions answered prior to receiving treatment. By signing this agreement, I consent to have Professional Sports & Orthopaedic Rehabilitation Associates, LLC provide assessment, treatment and care as prescribed by my physician and/ or recommended by my therapist. I further authorize Professional Sports & Orthopaedic Rehabilitation Associates, LLC, dba Game Shape Physical Therapy to release, to appropriate agencies, any information relating to claims for benefits submitted on behalf of myself and/or my dependents.

Please circle one: Patient / Guardian / Guarantor

PRINT Patient Name: _____

Signature: _____ **Date:** _____

If different:

PRINT Guardian/Guarantor Name:_____

Signature: _____ **Date:** _____

Consent for TELEHEALTH Physical Therapy Services (NEW)

I understand that I am a patient of Game Shape Physical Therapy and I will be receiving some or all of my Physical Therapy Visits via a TELEHEALTH secure online platform.

I understand that the TELEHEALTH sessions are hands-off sessions; and will consist of both visual observations and verbal communications about my musculoskeletal condition (Video and Audio).

I understand that the TELEHEALTH session will include 30 minutes of:

- Detailed discussions and Q&A about my current symptoms, a Coronavirus Screening, objective measures of my mobility and functional activities that I can perform in front of the camera, demonstrations from my Physical Therapist, and guidance on how I can help myself progress towards my goals (with common objects found around the home or physical assistance by a family member).
- After the call I will be emailed, an updated Home Exercise Program (HEP) if needed; and there will be a way for me to communication with my physical therapist through the HEP software (different then the TELEHEALTH software), and I can also send my questions to: info@GameShapeOnline.com or call the office line at (732) 617-8090.

My physical therapist has explained to me how the video conferencing technology will be used and how my visit will be beneficial to me as a patient, being that I will not be in the same room as my physical therapy provider. I also understand that (at this time) neither the video nor sound will be recorded.

I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my physical therapist or I can discontinue the TELEHEALTH treatment/visit if it is felt that the videoconferencing connections are not adequate for the situation. In addition, there may be risks involved with TELEHEALTH treatment, since my physical therapist will not be in the same physical space as me. I will have access to either family members' assistance, and/or my physical therapist will be allowed to activate EMS through 911, if necessary.

I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. These people will maintain confidentiality of the information obtained. I further understand that I will be informed if anyone other than my physical therapist, is within the immediate vicinity of the TELEHEALTH session, and thus I will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the TELEHEALTH vicinity: and / or (3) terminate the consultation at any time.

I have had the alternatives to a TELEHEALTH visit explained to me (i.e. Live Physical Therapy sessions at Game Shape Physical Therapy), and I am choosing to participate in TELEHEALTH physical therapy visits. I also understand that some parts of the physical therapy exam or treatment involving hands-on care or assistance, may be conducted and/or aided by individuals at my location (family or caregivers), at the discretion of my physical therapist.

I understand that billing will occur from Professional Sports & Orthopaedic Rehabilitation Associates, LLC dba Game Shape Physical Therapy, and through our Billing Company: "Systems4PT" (FOCUS Group). Many Insurance Plans are amending their Physical Therapy TELEHEALTH reimbursement policies, and many are also WAIVING Copays. I understand that I will not be personally billed, until my Insurance Plan has rejected the claim after several attempts.

Please Note: The best way to check TELEHEALTH coverage for yourself is to look on your Insurance Companies website under "Covid-19 Information" for telehealth coverage. Be advised that we are gathering all of the latest information and will continue to re-bill as allowed by our contracts. In the extreme circumstance that your TELEHEALTH visit will not be covered by you Insurance Plan(s), we reserve the right to bill and collect $55 per 30-minute TELEHEALTH visit.

By signing this form, I certify:

- That I have read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the TELEHEALTH procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Patient Name (PRINT): _____

Patient (or Guardian) Signature: _____ Date: _____ (Rev 3/30/2020)

LATE CANCELLATION / NO-SHOW POLICY

Please Read: Cancelling late or not showing up for an appointment causes needless stress, lost opportunity and financial hardship. Our office staff could have also used that valuable time to put in a new patient or a patient needing an additional appointment for the week. Being strict on this policy is imperative for our business. Thank you for appreciating our commitment to helping you and all our patients.

I understand that I will be charged a **$25.00 fee** if I fail to cancel and reschedule an appointment with less than **24 hours** advance notice; or if I need to be called because I have not shown up for my appointment time. The latter will be considered a "No Show" and a **$50.00 no show fee** will be my responsibility. Again, Regular Cancellations will be charged at a rate of $25, if the appointment is not rescheduled for the same week. **My insurance will not be billed.**

Acceptable modes of payment: Cash, Check or Credit Card. Due immediately on the next visit.

Please circle one: Patient / Guardian / Guarantor

PRINT Patient Name: _____

Signature: _____ **Date:** _____

If different:

PRINT Guardian/Guarantor Name:_____

Signature: _____ **Date:** _____

Thank You for Taking the Time to Complete this Very Important Packet of Information!

The Patient Health Questionnaire - 2 (PHQ-2)

Use: The purpose of the PHQ-2 is not to establish a final diagnosis or to monitor depression severity, but rather to screen for depression as a "first-step" approach.

Scoring: A PHQ-2 score ranges from 0 to 6; patients with scores of 3 or more should be further evaluated to determine whether they meet criteria for a depressive disorder.

PHQ-2 | Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several Days	More than one half the days	Nearly every day
1. Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
2. Feeling down, depressed, or hopeless	**0**	**1**	**2**	**3**

FOR OFFICE USE ONLY

I attempted to obtain the patient's initials and/or signature(s) in acknowledgement of these Notices and Agreements, but was unable to do so as documented below.

Sections without Initials and/or Signatures:

____ INSURANCE COVERAGE AND FINANCIAL RESPONSIBILITY
____ ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION
____ NOTICE OF PRIVACY PRACTICE
____ COMMUNICATION PREFERENCES
____ CONSENT TO TREATMENT / CONSENT FOR TELEHEALTH
____ LATE CANCELLATION / NO-SHOW POLICY

Date:	Reason:

Employee Name:	Employee Signature: