# Just Right at Home

Client Name:_________________________ Date of Birth:_________________
Phone #:_____________________________ Cell Phone #:_________________
Street Address:______________________________________________________
City/State/Zip Code:___________________ Email: ______________________
Insurance: Primary_____________________ Secondary:___________________

**CONSENT FOR RELEASE OF INFORMATION**

I hereby request and authorize any physician hospital or person who has attended or examined me, or who may hereafter attend or examine me, to disclose any and all information obtained thereby, relative to this condition, illness or injury to Just Right at Home, PLLC. I further authorize that Just Right at Home may share information with other professionals, agencies, durable medical equipment suppliers, or insurance companies that may be involved in the provision of necessary services or payment.

**CONSENT TO RECEIVE MEDICAL CARE**

I understand that I have been referred to Just Right at Home, PLLC for therapy services and that the evaluation and treatment process and plan of care will be explained to me. I understand that I have the right to ask questions at any time during the course of my care and that I may terminate or discontinue treatment at any time I wish. I consent to have Just Right at Home, PLLC provide services as prescribed by my physician and/or recommended by my therapist.

**RIGHT TO PRIVACY/HIPAA**

I fully understand the Notice of Privacy Practices and that under the Health Insurance Portability and Accountability Act, I have certain rights to privacy regarding my protected health information. I may request a copy of the Notice of Privacy Practices at any time. In compliance with HIPAA regulations, I consent to the following individuals receiving verbal information regarding my care:

Name/Relationship: ____________________________________________

Name/Relationship: ____________________________________________
I also authorize the release of appointment information left in a voice-mail, answering machine or text message and understand that there is some level of privacy risk associated with these forms of communication.

**CANCELLATION POLICY**

I agree to provide at least 24 hours notice when I need to cancel or reschedule an appointment and that cancellation of less than 24 hours or not showing up for an appointment will likely result in a cancel/no show charge of $50 depending on appointment type.

# Just Right at Home

Client Name:___________________________ Date of Birth:__________________

**FINANCIAL AUTHORIZATION AND RESPONSIBILITY**

I authorize payment to Just Right at Home, PLLC from Medicare and any other insurance carrier that I may be utilizing. My health insurance plan may provide a portion of the charges and balance will remain my personal responsibility, such as my deductible, co-payment, co-insurance or charges not covered or denied by my health insurance, Medicare, or other programs for which I am eligible. All co-payments and services not covered by my insurance plan are due at the time of service or upon presentation of invoice. I understand that in some cases payment may be directly mailed to me by the carrier and I will forward its payment to Just Right at Home, PLLC. As the owner of the insurance plan, it is my responsibility to know the terms and coverage policies. Please note that refusal to sign this form does not change responsibility for payment in any way.

**PERMISSION TO PHOTOGRAPH, VIDEO OR AUDIO RECORD**

I give permission to photograph, video and audio record me, my family, my caregivers and/or my home and for the purpose of analyzing issues related to the project. These recordings may be shared with other professionals to obtain their comments and recommendations to be used by Just Right at Home, PLLC during professional presentations, education purposes or marketing materials. Whenever the photograph or recordings are reviewed by others, Just Right at Home, PLLC will make every effort to ensure that the identity of the client shall remain confidential.

**CONSENT FOR EMERGENCY CONTACT INFORMATION**

Person to contact in case of an emergency:
Name/Relationship: _________________________________________________
Telephone Number:__________________________________________________
By my signature below, I certify that I have read, understand and fully agree to each of the statements in this document and sign below voluntarily.

__________________________________ ______________

Printed Name if Power of Attorney Date

____________________________________ ______________

Signature Date