CONSENT TO MEDICAL TREATMENT FROM SUNSHINE THERAPEUTICS, LLC.

Patient Name:
Date:

CONSENT TO TREATMENT: I hearby consent to the administration of occupational Therapy services as directed by Sunshine Therapeutics. This may include manual therapy, myofascial release, therapeutic exercise, kinesiotaping, and neuromuscular reeducation. I understand that the healing process varies for each individual and there are not guarantees or promises regarding the outcomes of this work.
I understand that occupational therapy services are designed to be a health aid and are in no way to take the place of a doctor's care when indicated. I am aware that the occupational therapist does not diagnose disease nor prescribe medications. I have stated all medical conditions that I am aware of and will keep my practitioner informed of any changes.

Information exchanged during any treatment session is educational in nature and is intended to help me become more aware and conscious of my own health status and is to be used at my own discretion. All information exchanged during a session will be kept confidential. I will inform my therapist of individuals in which I would like to be contacted regarding my treatments.
These individuals include:
1.

2.

3.

I authorize the release of medical records information to insurance carriers, third-party payers or their representatives, and/or review organizations as deemed necessary.

I have asked questions and received answers to my satisfaction to date knowing that as I progress with the work further questions may arise that will be answered to the best of the treating therapist? knowledge. If I experience any discomfort during the treatment, I will inform the therapist immediately. I have been instructed to wear clothing that I am comfortable wearing and that is appropriate for the treatment acknowledging that myofascial release is performed with direct touch to the skin.

I acknowledge that I have been informed of the nature, purpose, and risks of myofascial release treatments and my responsibilities in my own self-care. In order to facilitate my own self-care I may be instructed in techniques that are safe for me to complete at home. It is my responsibility to make sure I understand that in which I am instructed and listen to my body for guidance while completing self treatment techniques.

CANCELLATION POLICY: Cancellation of appointments less that 24 hours in advance will be charged $25. No show or call will result in full payment due. Further treatments will not be provided until payment is received.

FINANCIAL AGREEMENT: Payment is due at the time of services provided. I understand that I, the client am responsible for verifying insurance coverage, filing for authorization, submitting records for reimbursement if desired. Payment records and clinical records will be provided on request so that individuals may file for reimbursement if desired.

Client Signature:_____Date:_____

For minors: I, as parent of_____, have read and agree with the above information giving consent for the treatment of my child.