



708 SE 4th St
College Place WA 99324

509 540 2862
509 527 8838 fax

Authorization for Therapy Treatment

- I consent and authorize CoreFit Enterprises to provide Physical Therapy Services as agreed upon.

Release of Information

- I understand that CoreFit will maintain medical records regarding the services provided meeting state and Federal guidelines for retention of such records.
- I understand that I may obtain a copy of my records by requesting such from CoreFit and I understand that it may take up 7-10 days for retrieval and copying of the records.
- I understand that if I am a minor, my parents may be legally entitled to some information about my treatment. My therapist will discuss with me and my parents what information is appropriate for them to receive, and which issues are more appropriately kept confidential.

Payment for Services

- I understand that CoreFit is a fee-for-service organization and expects payment at the time of service based on a rate of \$100 per hour with a one-hour initial evaluation required on the first visit.
- I understand that Mobile Physical Therapy is available with a surcharge of \$20 within 10 miles of address above, and travel outside the 10-mile radius is based on hourly rate of \$100 per hour prorated on a case-by-case basis.
- I understand there will be a \$20 fee charged for any returned checks.
- I understand that CoreFit is not a provider for any insurance company. CoreFit will provide you with invoices containing appropriate information for you to submit to your insurance company.

Electronic Communication

- I understand that while CoreFit and its representatives do take precautions regarding electronic communication, CoreFit and Kimberly Cole cannot ensure the confidentiality of any form of electronic communication outside of our secure client portal currently hosted by Citrix. If I choose to communicate via email or text message, I understand and accept the risk.
- I understand that all my records, except handwritten notes, are stored in the client portal, Citrix, which is accessible to you through your own username and password. This is a secure client portal.

Cancellation Policy

- I understand that, if I should need to cancel my appointment, I should give 24 hours' notice in advance, if possible.

Term

- This patient consent and authorization given to CoreFit Sports Fitness & Rehab as set forth above will remain in full force and effect until terminated in writing by patient or authorized patient representative.

Signature of Patient: _____ Date: _____

Signature of Authorized Patient Representative (If applicable): _____ Date: _____

Name: _____ Relationship to Patient: _____

Witness Signature: _____ Print Name: _____ Date: _____