AGREEMENTS AND AUTHORIZATIONS

**CONSENT FOR TREATMENT** I hereby authorize and consent to treatment provided by Motivate, employees or designees and authorize medical services, diagnostic procedures as deemednecessary or advisable by the caregiver(s) providing treatment. I understand that no guarantee has been made as to the results of the care or treatment, which may be given to me.

**NOTICE OF PRIVACY PRACTICES-NPP**

Notice of Privacy Practices provides detailed information about how the practice may disclose my confidential information. Statement of Privacy Practices will be included in my Patient Take Home Folder. I understand I may request Statement prior to attending my appointment. I understand that Motivate has reserved the right to change their privacy practices and a copy of any Revised Notice will be provided to me or made available.

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**  Evaluation reports and/or clinical information is automatically sent to your referring provider. Any other records for any other reason will not be released without a completed and signed records release form from you.

**ASSIGNMENT OF INSURANCE BENEFITS/REFERRALS/PAYMENTS GUARANTEE/COLLECTION FEE/NSF FEE** I hereby authorize payment to be made directly to Motivate for insurance benefits payable to me. I understand that I am financially responsible to Motivate for any covered or non-covered services, as defined by my insurer, which are not paid by my primary or secondary insurer. I understand I am financially responsible for payment in full if no required referral is received by this office. I understand that I am financially responsible for any collection fee and any reasonable attorney’s fees and other costs incurred for collection including but not limited to 1 ½% interest per month on any outstanding amounts unpaid 90 days after insurance resolution. I understand that I am financially responsible for a returned check for any reason and a $25.00 NSF fee. I understand that I can be terminated from the practice for monetary reasons ***or*** non-compliance with medical advice.

**PAYMENT POLICY**  I understand a courtesy insurance benefits quote may be provided to me. I understand this courtesy quote is not a guarantee of benefits and for accurate details regarding my benefits I should contact my plan administrator, health benefits coordinator or other designated agent. I also understand I may be required to sign an agreed upon payment policy based on findings from courtesy benefits quote. Self Pay Program payments are due at the time of service. The Adult/Guardian who brings a Minor will be responsible for any designated payments.

**IF MY INSURANCE CHANGES OR I HAVE NO CURRENT INSURANCE CARD(S) AT TIME OF SERVICE** If I do not have my current insurance card(s) for any date of services, I will be billed as a Self Pay. Motivate might not be able to back date from the time of service to when I do present my current insurance card(s) to Motivate. I may be asked to seek reimbursement from my insurance carrier(s).

**MEDICARE** Patient’s Certification, Authorization to Release Information and Payment Request. I certify that the information given by me in applying for payment under TitleXVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf directly to Motivate.

**PATIENT ACKNOWLEDGEMENT** I have read the Agreement and Authorization form and I understand its contents and that I have had an opportunity to discuss its contents to my satisfaction. I understand that my signature represents agreement with the contents of the form and that any statement may not amend to contents of the form. I understand that the records/information released will not be further disclosed for any purpose other than as stated in this Authorization.

X \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ X \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ X \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 Patient or Authorized Representative PRINTED NAME Patient or Authorized Representative SIGNATURE Date

**Authorization to Release Protected Health Information
to Family Members or Other Individuals**

In the event of a critical episode or if you are unable to provide authorization due to the severity of your medical conditions, HIPAA allows Motivate to disclose, without authorization, your protected health information as necessary to provide appropriate medical care.

**Please check the appropriate box below (or leave blank):**

\_\_\_\_\_ **I authorize**Motivate to release information concerning my medical care to the following individuals\*:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 Name (please print) Relationship Telephone #

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 Name (please print) Relationship Telephone #

\_\_\_\_\_ **I DO NOT** authorizeMotivate to release any information to any individual

\*This authorization does not expire unless you notify Motivate, in writing, of revocation

**Authorization for Motivate to Leave Voice Messages**

You are automatically enrolled in automated appointment reminder calls. You should receive a reminder call 72 hours prior to your appointment.

1. You are automatically enrolled in automated appointment reminder calls.
 You should receive a reminder call 72 hours prior to your appointment.

***If you do not wish to receive automated reminder calls, or would prefer to receive text reminders, please inform our Customer Care Team.***

2. On occasion, we may need to contact you. A detailed voicemail may be necessary.

**Please check the appropriate box below:

\_\_\_\_ I AUTHORIZE** detailed voice messages

 **\_\_\_\_ I** **DO NOT** authorizedetailed voice messages

 **Please fill out this form as completely as possible.**

**This will help your therapist develop a safe and appropriate treatment for you.
We appreciate your input!**

Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*We recognize that the identities you carry might differ from legal and insurance identification. To ensure we are identifying you correctly while also avoiding billing/claim errors, please complete this section to your level of comfort.*

Legal Name for Billing/Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Chosen First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Sex Assigned at Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current gender identity: □ He/him □ She/her □ They/them □ Another pronoun\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency Contact Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Preferred Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ FT \_\_\_\_\_PT \_\_\_\_\_Retired \_\_\_\_\_Unemployed Hours/Week\_\_\_\_\_\_\_ On disability or leave? \_\_\_\_\_\_\_ Activity Restrictions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your primary problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When and how did your problem begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is this…** Work related\_\_\_\_\_ Injury Date\_\_\_\_\_\_\_\_\_\_ Auto Related\_\_\_\_\_ Injury Date\_\_\_\_\_\_\_\_\_\_ N/A\_\_\_\_\_

 **Other/Describe**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgery for this condition? □ Yes □ No Date of surgery \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_

Type of surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any previous treatment for this condition? □ Physical Therapy □ Occupational Therapy
□ Injection □ Chiropractic □ Pain Clinic □ Acupuncture □ Massage Therapy □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are your symptoms? □ Constant □ Comes and goes daily □ Occasional (< daily) □ Sporadic (< weekly)

Symptom Description: □ Aching □ Stabbing □ Burning □ Dull □ Steady □ Throbbing
 □ Numbness/Tingling □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Can you get comfortable at night? □ Yes □ No Does time of day affect your symptoms □ Yes □ No

 **No pain 0 1 2 3 4 5 6 7 8 9 10 Intolerable pain**

 *Circle your pain estimate (if applicable)*

 **Not interfering 0 1 2 3 4 5 6 7 8 9 10 Completely interfering
with quality of life with quality of life**

 *Circle your perceived severity of symptoms*

**What are your goals with therapy?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Activities/events that cause or aggravate your symptoms. Check all that apply**

□ Sitting greater than\_\_\_\_\_\_minutes □ With cough/sneeze/straining

□ Walking greater than \_\_\_\_\_\_minutes □ With laughing/yelling

□ Standing greater than \_\_\_\_\_\_minutes □ With lifting/bending

□ Changing positions (e.g., sit to stand) □ With cold weather

□ Light activity (light housework) □ With triggers (e.g., key in door)

□ Vigorous activity/exercise (run/weight lift/jump) □ With nervousness/anxiety

□ Sexual activity □ No activity affects the problem

□ Other, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How has your lifestyle/quality of life been altered/changed because of this problem?**

Social activities (exclude physical activities), specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diet/Fluid intake, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physical activity, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**General Health (circle one):**  Excellent Good Average Fair Poor

**Mental Health** Current level of stress: High Med Low Current psych therapy? Y/N

**Have you ever had any of the following conditions or diagnoses? Check all that apply**

|  |  |  |
| --- | --- | --- |
| □ Cancer | □ Anemia | □ Childhood bladder problem |
| □ Heart problems | □ Osteoporosis | □ Irritable Bowel Syndrome |
| □ High blood pressure | □ Deep vein thrombosis/Embolism | □ IBD (Crohn’s/UC) |
| □ Ankle swelling | □ Headaches | □ Pelvic pain |
| □ Epilepsy/Seizures | □ Head injury | □ Hepatitis  |
| □ Multiple Sclerosis | □ Emphysema/Chronic bronchitis | □ Low back pain |
| □ Fibromyalgia | □ Asthma | □ Sacroiliac/Tailbone pain |
| □ Diabetes | □ Allergies (list below) | □ Sexually Transmitted Infection |
| □ Hypo/Hyperthyroid | □ Latex sensitivity | □ Physical/Sexual Abuse |
| □ Stroke  | □ Arthritic conditions | □ Kidney disease |
| □ Substance abuse | □ Joint replacement  | □ Current infection (describe below) |
| □ Raynaud’s Syndrome | □ Bone fracture | □ Frequent UTIs |
| □ Acid reflux/Belching | □ Sports injuries | □ History of MDROs (MRSA, VRE, etc.) |
| □ Anorexia/Bulimia | □ TMJ/Neck pain | □ Other communicable diseases |
| □ History of smoking□ Chronic Fatigue Syndrome | □ Vision/Eye problems□ Hearing Loss/Problems |  (describe below) |

**Other/Describe**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**Surgical/Procedure History**

Y/N Surgery for your back/spine Y/N Surgery for your bladder/prostate

Y/N Surgery for your brain Y/N Surgery for your bones/joints

Y/N Surgery for your female organs Y/N Surgery for your abdominal organs

**Other/Describe**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications - pills, injection, patch** **Start date** **Reason for taking**
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Over the counter - Vitamins etc.**  **Start date** **Reason for taking**
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **X** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **X** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Patient or Authorized Representative Signature Date

 **LATE CANCEL / NO SHOW POLICY –** *revised 8/26/21*

**Motivate Health, Inc. requires 48-hour notice for all appointment cancellations**

* **IF Motivate Health, Inc. does not receive 48-hour notice,** you will be charged a
$100 fee tocover the cost of the visit.\*

 **\****Exceptions from this charge are contagious illness or pandemic restrictions*

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

* **Cancellations are accepted only by calling during Motivate**

**office business hours Monday – Friday 8am – 4:00pm\***

**\****Monday and Tuesday appointments - voice message cancellations recorded on*

*Motivate voice mail Saturday or Sunday are acceptable and must be*

*recorded 48 hours prior to appointment*

* **Email, text, and social media messages to cancel are not acceptable**

*No exception*

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

*Courtesy automated text message appointment reminders are available.*

*See our Customer Care Team for details.*

*Our goal is for you is to complete an agreed upon a personalized Plan of Care in a reasonable amount of time. Your dedication to keeping your scheduled appointments is key to your success.*

*We reserve one hour time slots to provide you with highest quality of care.
To provide this type of care, it is imperative that you attend your scheduled commitment.*

*Late cancellations and no shows limit opportunities for patients waiting for access to excellent care.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Printed Name**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient signature of acknowledgement Date**

***Motivate Health, Inc. reserves the right to cancel future scheduled appointments due to
2 consecutive late cancels or no shows***