



INFORMED CONSENT

www.naturalbalancetherapy.com

I give Natural Balance Therapy, LLC (NBT) consent to provide therapeutic services as ordered by my physician, or as requested by myself.

Summary of Policies:

_____ **Cancellation and Lateness:**

- We request that all clients extend a courteous 24-hour cancellation notice to change or cancel any appointments. If a client does not arrive within 15 minutes of the appointed time or cancel with at least 24-hour notice, he or she may be subject to a service fee. Emergency cancellations are determined at the therapist's discretion (Work is not considered an emergency).
- Sessions begin and end at scheduled times.

_____ **Payment and Bad Check:**

- Full payment is due at time of service.
- I understand that there will be a \$40.00 charge applied to my personal balance for any check that is returned to the office.

_____ **Flexible Spending and Health Savings Account (HSA):**

- If you are submitting to your flexible spending or HSA, a Doctor's prescription is required (we have orders that you can take to your Doctor to sign). Receipts you need to submit to your flexible spending or HSA will be provided as you request it.

_____ **Photograph Policy:**

- By initialing you consent that your postural photographs can be used in an educational and professional manner (pictures will not be shared and are for educational purposes between therapist and client).

_____ **Product Checkout:**

- I understand that any products checked out from the library are the property of NBT. If the product is not returned by the due date then I agree to pay for the cost of replacing the product.

_____ **Privacy Policy:**

- Please note that email addresses and contact information will be used only to forward educational material and for professional reasons.
- All information discussed during sessions and in your chart is held in the utmost confidence.

Authorization for release of information:

I certify that the information given by me is correct. I hereby authorize the attending therapist to release any info concerning my examination or treatments to my insurance carrier or other medical professionals involved in my care.

I have read and understand the above office policies. I hereby agree to pay directly to this office for professional services rendered and shall be personally responsible for any unpaid balance to this office.

Client's Signature: _____

Date: _____

Responsible party's signature: _____

Relationship: _____