Geril Therapy

Consent For Treatment

I, the undersigned, a patient at Geril Therapy, do hereby authorize GERIL THERAPY, and whoever they designate a therapist, or assistant to administer treatment as is necessary. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that as a courtesy GERIL THERAPY will prepare insurance forms and bill my insurance company directly.

I hereby request assignment of payment of all insurance benefits to Geril Therapy. I am ultimately responsible for payment of all services rendered, unless otherwise provided by law.

Deductibles/Percentage pays and/or Co-Payments

Co-payments are to be paid at time of service, unless prior arrangements have been made with the Office Manager. Deductible and percentage payment amounts will be billed at the time the payment from your insurance company is received. Payment is due within 30 days of the date on the invoice. Patients are to keep payments current.

Cancellation/No-Show Policy

I understand that cancellations should be made within 24 hours prior of their scheduled time, unless extenuating circumstances prevent otherwise.

A $25.00 fee may be enforced for no shows or late cancellations. By signing below you are agreeing to all the above terms and conditions.

Additionally I confirm that I have received a copy of GERIL THERAPY's Privacy Practices.

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Patient or Legal Guardian's Signature Date Witness Signature Date