DOUGLAS G. DEWEY, P.T., PC.
SELF PAY

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for Douglas G. Dewey,PT, OCS to furnish medical care and treatment to _____ as considered necessary and proper in treating his/her physical condition.

_____

Patient/Parent or Guardian Date

FINANCIAL RESPONSIBILITY AGREEMENT

Initial evaluation - $95.00
Cost per visit after initial evaluation - $65.00
One hour treatment session is $125.00.
(this does not include the initial evaluation)

You are responsible for payment at the time services are rendered, you will be responsible for the entire cost of the visit that would normally be charged.

We can accept payment from you with a credit card, cash or check.

Please verify that you understand your financial responsibility by signing and dating this form.

_____

Patient/Parent or Guardian Date

Email:_____

MISSED APPOINTMENTS

Unless cancelled a least **24 hours** in advance, our policy is to charge **$40.00** for missed appointments.

_____

Patient/Parent or Guardian Date