Patient Communication Authorization

Do you give permission allowing J2 Therapy and Wellness to leave clinical permission on your voicemail? Please initial:

_____ YES _____NO

If you anticipate that you will need or want your medical information provided to family members, friends, or caretakers/babysitters, please indicate below. If you do not want any of your medical information provided to a family member please check no.

Spouse: _____ _____YES _____NO

Parent: _____ _____YES _____NO

Other: _____ _____YES _____NO

Patient or Responsible Party Signature: _____

Print name of Patient or Responsible Party: _____

Do you give permission allowing your therapists at J2 Therapy and Wellness to discuss your case with other medical professionals who are also involved in your case? This would include physicians, nurse case managers, and/or other therapists in order to best collaborate and provide the highest level of care for the rehabilitation of your injury. Communication with other medical professionals may occur over the phone, through an electronic record or access through an online portal. If you do not want any of your medical information provided or discussed with other medical professionals please check no.

_____ YES _____NO

Referring Physician: _____

Primary Care Physician: _____

Patient or Responsible Party Signature: _____Date _____

In order to establish optimal relations with our patients and avoid misunderstandings and confusion regarding our payment policies, our staff is trained to consistently inform you of your financial payment policies of our office. Payment is required for all services at the time they are rendered. For all patients, applicable copayments and/or out of pocket expenses will be collected. We accept payment in the form of cash, check and credit card. In the event that your account must be turned over to collections, the patient responsibility will include the actual cost of collections including but not limited to court / attorney fees. In the event that an appointment is not cancelled within 48 business hours, you will be charged a $90 fee. Your signature below signifies your understanding and willingness to comply with this policy.

Patient / Responsible Party Signature: _____ Date _____