



2200 Harvard Road, Suite 101  
Lawrence, Kansas 66049  
Phone: (785) 842-0656  
Fax: (785) 842-0071

**Patient Consent and Authorization**  
**Lawrence Therapy Services**  
**Baldwin Therapy Services**

814 High, Suite A, PO Box 368  
Baldwin City, Kansas 66006  
Phone: (785) 594-3162  
Fax: (785) 594-3257



Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Street Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Driver's License # \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Treatment in: Home  Office

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Primary Physician: \_\_\_\_\_

<b>Insurance Information:</b>	
Primary: _____	Phone #: _____
Policy #: _____	Group #: _____
Secondary: _____	Phone #: _____
Policy #: _____	Group #: _____

How did you hear about us?  Radio  Doctor  Public Presentation  Friend/Family  Social Worker  
 Newspaper  Previous patient to our clinic  Website  Other \_\_\_\_\_

**Consent to Treat/Release of Information:** I give Lawrence Therapy Services LLC consent to evaluate and treat my condition and permission to discuss my plan of care with my physician and/or any other health care professionals necessary to improve the quality of my care. I give permission for Lawrence Therapy Services LLC to release information to any pertinent health care provider and/or my insurance company/companies. Please list anyone (*besides your physician or other medical providers*) you permit Lawrence Therapy Services LLC to share your private health information with (i.e. relative, friend, etc.): \_\_\_\_\_  
Please list anyone you **DO NOT** want Lawrence Therapy Services LLC to share your private health information with: \_\_\_\_\_

**Consent to Bill:** I give authorization for Lawrence Therapy Services LLC to bill my insurance for the services rendered as well as permission for my insurance company/companies to submit payment directly to Lawrence Therapy Services LLC for services rendered. I also give Lawrence Therapy Services LLC permission to talk to the Insurance Commissioner on my behalf.

**Financial Policy:** I understand that I am responsible for any amount not covered by my insurance. *Estimated co-payments and deductibles are due at the time of service.*

**Cancellation/No-show policy:** I understand I am responsible for a **\$50 CANCELLATION FEE** if I do not attend or am not available for a scheduled appointment without giving a 24-hour notice of cancellation.

**Patient Bill of Rights:** I have received Lawrence Therapy Services LLC "Patients Rights and Responsibilities" and have read and understand my rights as a patient of Lawrence Therapy Services LLC. "The Notice of Privacy Practices" required by the *Health Insurance Portability and Accountability Act (HIPAA)* has been provided for my review and I have been given the opportunity to ask questions regarding the notice.

My signature below indicates that I have read, understand, and agree to the above conditions:

**Patient Full Name (please print):** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Responsible Party/DPOA Name (if applicable):** \_\_\_\_\_

**Responsible Party/DPOA Address:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**Responsible Party/DPOA Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_