CONDITIONS & CONSENT FOR PHYSICAL THERAPY EVALUATION/TREATMENT

I understand that I am a patient of Connections Physical Therapy, LLC.

Cooperation with treatment:

In order for physical therapy treatment to be effective, I must attend scheduled appointments unless there are unusual circumstances. I understand and agree to cooperate with and perform the home physical therapy program intended for me. If I have trouble with any part of my treatment program, I will discuss it with my therapist.

*****Cancellation policy:**

I understand that if I cancel more than 24 hours in advance, I will not be charged. I understand that if I cancel less than 24 hours in advance or no show for my appointment, I will pay a cancellation fee of $40.00. This fee will be waived in the case of emergency, illness or extreme weather.

No warranty:

I understand that there are no guarantees regarding a cure for or improvement in my condition. I understand that my physical therapist will outline and discuss goals of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

Informed consent for treatment:

The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy have been explained to you. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the treatment options available for my condition.

Potential risks:

I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing condition. This discomfort is usually temporary. If it does not subside in 24 hours, I agree to contact my physical therapist.

Potential benefits:

I may experience an improvement in my symptoms and an increase in my ability to perform daily activities. I may experience increased strength, awareness, flexibility, and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available.

Alternatives:

If I do not wish to participate in the therapy program, I will discuss my medical, surgical, or pharmacological alternatives with my physician or primary care provider.

Release of medical records:

I authorize the release of my medical records to the following:_____

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Financial responsibilities:

I agree to pay for the treatment in full at the time of service, by cash, check, or charge card. I understand that Connections Physical Therapy, LLC does not bill insurance companies and is unable to treat traditional Medicare fee-for-service beneficiaries. I understand that, if I want to use my insurance benefits, it is my responsibility to contact my insurance company ahead of time to discuss out of network benefits and obtain any pre-authorization or physician referral that is necessary. I understand it is my responsibility to submit my own claims to my insurance company and there is no guarantee of reimbursement for the services provided.

I have read the above information and consent to physical therapy evaluation and treatment.

_____ _____

Print name Date

_____ _____

Patient or parent/guardian signature Therapist signature

Effective date 2/1/2016