Conditions & Consent for Physical Therapy

I understand that I am a patient of ProAction Physical Therapy, a private, therapist owned Physical Therapy practice.

Cooperation with Treatment In order for Physical Therapy treatment to be effective, I must come to 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 Physical Therapist.

Cancellation Policy I understand that to successfully achieve the goals of treatment established by myself and my physical therapist, it is essential for consistent attendance, as outlined by my plan of care. I understand that three (3) no shows could result in my discharge from therapy. I understand that if I cancel in less than 24 hours in advance, I will pay a cancellation fee of $25.00, which is to be paid at the time of my next appointment.

Limitations I understand that there are no guarantees regarding a cure for, or even 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 said treatment. There may be times where my insurance company will withhold payment for certain services rendered, but care will be taken to inform me of such circumstances prior to rendered services.

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

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

Potential Benefits I understand 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 can expect to gain a greater knowledge about managing my condition and the resources available to me.

Alternatives I understand that 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.

Financial and Insurance Responsibilities I understand it is my responsibility to call my insurance company ahead of time to obtain any pre-authorization or referrals necessary, and to obtain verification of my outpatient physical therapy benefits. I understand that ProAction Physical Therapy will call my insurance carrier prior to my initial evaluation as a courtesy to me, but ultimately it is my responsibility to confirm that the information ProAction Physical Therapy receives is accurate. If I have any questions regarding my insurance coverage, I understand that I can ask my insurance carrier or ProAction Physical Therapy for further assistance. I further understand that my insurance is a contract between me, my employer (if provided) and the insurance company. ProAction Physical Therapy is not a party to that contract. As a therapy provider, ProAction Physical Therapy's relationship is with me and not my insurance company. ProAction Physical Therapy will submit an insurance claim as a courtesy, but I am responsible for all charges from the dates services are rendered. I understand that payment for services is due at the time services are rendered. Payment can be made by cash, check, Visa, MasterCard or American Express. I understand that returned checks or balances over 60 days may be subject to additional collection fees and interest charges of 1.5% per month. All balances over 90 days past due may be sent to a collection agency. I understand that should my account be sent to a collection agency, I will be financially responsible for all collection and legal fees incurred as a result of collecting the balance.

Notice of Privacy Policies I understand that I was provided with a copy of the Notice of Privacy Policies utilized by ProAction Physical Therapy in compliance with regulations under the Health Insurance Portability and Accountability Act (HIPAA) Sec.45 CFR 160 and 164. I understand my privacy rights as a patient of ProAction Physical Therapy.

By signing this form, I am acknowledging that I have read the above information and I consent to the Physical Therapy Evaluation and all subsequent treatment thereafter.

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Patient Signature **Date**

Please Note: If patient is under 18 years of age, a parent / guardian must sign this form as well.

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Parent / Guardian Signature **Date**