Patient Name:

KASSIMIR PHYSICAL THERAPY, PA
CONDITIONS & INFORMED CONSENT FOR PHYSICAL THERAPY

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 Exercise 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 if I cancel 24 or more hours in advance, I will not be charged; if I cancel with less than 24 hours' notice, **I will be charged a $25 fee, not covered by insurance, to be paid at my next visit.** If I fail to call to cancel and fail to keep a scheduled appointment, **I will be charged a $50 no-show fee.** Fees are due at next visit. I understand that 3 no-shows could result in my discharge from therapy.

Limitations: I understand that there are no guarantees regarding a cure for, or improvement in, my condition. I understand that my Physical Therapist will outline goals of Physical Therapy treatment for my condition and will discuss treatment options with me before I consent to treatment. There may be times when my insurance company will withhold payment for certain services rendered, but care will be taken to inform me, whenever possible, of such circumstances prior to rendering those services.

Informed Consent for Treatment: I understand "Informed Consent" means that potential risks, benefits of, and alternatives to Physical Therapy treatment have been explained to me. The Therapist provides a wide range of services; I understand that I will receive information at the Initial Evaluation visit concerning options available for treatment of my condition.

Potential Risks: I understand that I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury or condition, and that this is usually a temporary condition. If the discomfort 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, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I can expect to gain a greater awareness and knowledge of how to manage my condition, and what resources are available to assist me.

Alternatives: I understand that if I do not wish to participate in the Physical Therapy program, I will discuss my medical, surgical, or pharmacological alternatives with my Physician or Primary Care Provider.

Financial/Insurance Responsibilities: I understand it is my responsibility to call my insurance company ahead of time to obtain any necessary pre-authorization and to obtain verification of my outpatient Physical Therapy benefits, including any co-payments, co-insurance and deductible payments due at time of service. I understand that KPT calls my insurance company as a courtesy to me, but that I am responsible for verifying that the information given to KPT is accurate. If I have questions about insurance coverage, I understand that I need to contact my insurance company for assistance.

Notice of Privacy Policies: I acknowledge that I was provided with the Kassimir Physical Therapy, P.A., Notice of Privacy Policy, which is compliant with regulations under the Health Information Portability and Accountability Act (HIPAA).

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Name (print please) Date

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Signature of Patient (or parent/guardian if patient is a minor) Witness