Consent for Physical Therapy Care

I hereby consent to the evaluation and treatment of my condition by a licensed physical therapist at The Recovery Room Physical Therapy and Athletic Center, LLC.

The physical therapist has fully explained to me the nature and purpose of the procedures, evaluation and course of treatment. The physical therapist has informed me of expected benefits and possible compilations or discomfort, which may result from skilled physical therapy care. In addition, the physical therapist has explained to me the risks of receiving no treatment.

I understand it is my responsibility to know my physical therapy benefits as provided under my health care plan. I hereby assign all benefits directly to The Recovery Room Physical Therapy and Athletic Center and authorize the release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.

The physical therapist has explained that there is no guarantee that the proposed course of treatment will improve my condition and that it is possible, although unlikely, that the course of treatment may cause additional pain or discomfort or aggravate my condition. I have been given an opportunity to ask questions, and all my questions have been answered to my satisfaction. I confirm that I have read and fully understand this consent form.

Patient/ Guardian Name ____ *Date* ___________________________

Patient Signature ____ *Therapist Initials* ______________________________

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received and read the Notice of Privacy Practices provided to me by The Recovery Room Physical Therapy and Athletic Center.

Patient/ Guardian Name ____ *Date* ___________________________

Patient Signature ____ *Therapist Initials* ____________________________

Cancellation Policy

Your appointment time is valuable and it has been reserved solely for you. If you are unable to keep a scheduled appointment, we require 24 hours' notice. We reserve the right to charge a fee of $50 in the event notice is not provided.

Patient Signature ____