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Informed Consent for Physical Therapy Services

Physical therapy: the purpose of physical therapy is to treat disease, injury and disability by examination, evaluation and intervention by use of rehabilitative procedures, mobilization, manual techniques, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. All procedures will be thoroughly explained to me before they are performed.

Informed Consent for treatment: The term " informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to me. I understand that the physical therapist provides a wide range of services and I will receive information at the initial visit concerning the treatment and options available for my condition.
I will notify my practitioner if I am pregnant, become pregnant, or am trying to get pregnant. I understand I am encouraged to communicate with a physician the potential benefits and risks of treatment relevant to my pregnancy.

Potential Benefits: Benefits may include an improvement in my symptoms and an increase in my ability to perform my 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 to me.

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

No Warranty: I understand the my physical therapist cannot make any promises or guarantees regarding a cure for or improvements in my condition. I understand that my physical therapist will share with me her opinions regarding potential results of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

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.

Insurance: I, the patient, am ultimately responsible for payment of my account. As a courtesy, Arete Rehab, PLLC will bill medicare on my behalf or provide me with a super-bill if my insurance is out of network. **I am responsible for paying any deductible and/or co-payment due at time of service. After 60 days any balance not paid by insurance will become my responsibility.**

I may elect to pay out of pocket for physical therapy services. Patients without insurance or for those who elect to pay out of pocket, a discounted "cash rate" of $230.00 for initial evaluation and $120.00 for follow-up appointments will apply. Payment will be due at the time of service.

Cancellation Policy: In the event that I need to cancel a scheduled appointment, I agree to provide the courtesy of 24-hour notice so that Arete Rehab, PLLC can offer my appointment to patients waiting on the standby list. If I fail to give 24-hour notice of a cancellation, I understand that I will be subject to a fee equal to the full visit rate.

I have read the above information and I consent to physical therapy evaluation and treatment. My signature below acknowledges that I have read, understood and will abide by the conditions and policies noted on this consent form.

_____ _____

Printed Name of Patient Date

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Patient's Signature (if patient is a minor, parent or legal guardian must sign)