CONSENT FOR MEDICAL AND ASSUMTION OF RISK:

I have been informed that participation in Physical Therapy (PT): may include exercises for strengthening, condition, flexibility, agility and may involve the use of equipment. Such participation has potential mental/physical risks.

During my treatment at Advanced Physical Therapy I agree to the following:

- My participation in PT is strictly voluntary
- My participation in each exercise and activity is voluntary and I may choose to limit my participation in any activity at any time.
- I am personally responsible for my own safety during PT. I will monitor and pace myself in a manner that is safe while still actively engaging in each activity.
- I will advise my Physical Therapist of any changes in my physical or mental health prior to participation in each session. I understand that failure to provide this information may have a negative effect with my treatment.
- My Physical therapist is available to answer any questions that I might have regarding my participation in PT and failure to ask these questions may negatively impact my treatment.
- I will seek further direction for anything that I do not fully understand, or that causes me concern.

I hereby accept the responsibility for any harm, injury, or damage that may result from my participation in PT. I hereby waive, release and agree to hold harmless Advanced Physical Therapy for any claim arising out of any injury to me.

ASSIGNMENTS OF INSURACE BENEFITS AND PATIENT RESPONSIBILITY:

By signing this form, I authorize Advanced Physical Therapy to submit medical claims on my behalf to my insurance provider. I understand and acknowledge that submission of claims is not a guarantee of payment. I understand that it is my responsibility to notify Advanced Physical Therapy of any changes to my insurance carrier or coverage as soon as possible. Any failure to report such changes will result in the patient being financially responsible for any lapse in coverage or authorization. If for any reason my carrier does not cover any and/or all of my physical therapy treatments, I agree that I am responsible for the payment of the entire amount. These include deductible, co-payment, and/or non-covered benefits. In the event of default, I shall be responsible for all costs of collection and reasonable attorney fees. Furthermore, I authorize payment of medical benefits to which I am entitled, to Advanced Physical Therapy for medical services rendered. I understand that payment is due at the time of service. We accept cash, personal checks, debit and major credit cards. We reserve the right to charge a $35 insufficient funds fee for returned checks.

CANCELLATION and LATE ARRIVAL POLICY:

When a patient doesn't show for an appointment as scheduled:

- You suffer because you do not receive the treatment needed to prescribe by your doctor and/or PT.
- The therapist now has a space on their schedule that could have been used for another patient in need.

We require the following to avoid a $30.00 charge:

- 24 hours' notice in the event of a cancellation.
- Unusual circumstances will be considered on a case by case basis.
- All NO SHOWS will be charged.

This charge WILL NOT be covered by insurance, so it will be billed to you permanently.

IF YOU ARRIVE LATE for your scheduled appointment you will be given one of the following options per your therapist:

- You may need to reschedule the appointment
- Wait for a same-day opening in the schedule, that will permit the scheduled work to be completed or
- If possible a portion of the scheduled work will be completed during the remaining appointment time.

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Printed Name of Patient **Signature of Patient or Guardian**

_____ _____

Reviewed By **Date**