CROSSROADS
PHYSICAL THERAPY

CONSENT FOR TREATMENT

As a patient you have the right to be informed about your health condition(s) and about recommended rehabilitation treatments. This document provides information that you may use for the purpose of deciding to give or to withhold your consent to be provided with care at Crossroads Physical Therapy, LLC.

I, _____, request and consent to examination and treatment for Physical Therapy.

I further understand that I have the right to ask questions about:

- the nature or goals and potential benefits of any proposed care
- all aspects of examination and treatment, my condition, diagnosis or prognosis
- the inherent risks, complications, or side effects of treatment
- the likelihood of improvement or success following intervention
- reasonable, available alternatives to the suggested care and character of treatment

Potential risks I may experience include 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 therapist. Potential benefits I may experience include an improvement in my symptoms and an increase in my ability to perform movement and daily activities. I may experience increased strength, awareness, flexibility and endurance with activity. I may experience decreased pain and discomfort. I will learn strategies for managing my condition and resources available to me will be shared. It is anticipated that physical rehabilitation will allow improved function through decreased pain, increased strategies for managing pain, weakness, or immobility.

FEE FOR SERVICE PRACTICE

I have reviewed the clinic fees and understand that I am responsible for payment at the time of service. I understand that I will not be able to submit for reimbursement by Medicare. I understand it is my responsibility to call my insurance company ahead of time, obtain any pre-authorization that is necessary, and get an estimate of my benefits. I understand that upon **written request** my therapist will provide me with a receipt (Superbill) that is my responsibility to submit to my insurance company if desired. _____Initials

CANCELLATION AND NO SHOW POLICY

* A 24 hour notice is required for all cancellations.
* Cancellations may be performed via phone call or email.
* If you fail to cancel within the 24 hour parameter, you may be charged the full amount of the service for which you were scheduled.
* The earlier you give notice of your need to cancel, the earlier that appointment time can be offered to another patient. This is important as you might benefit from this service yourself at some point. Please keep in mind that not keeping appointments and failing to give adequate notice, affects not only Crossroads Physical Therapy, but also the other patients on the roster who might like to be seen.
* Even though the scheduling program is automated to send a reminder email or text, based on your preference, there may be times when the system fails. It is the patient's responsibility to know when their appointment time is scheduled, to check with the clinic to confirm if needed, and to arrive on time.
* If late cancellations or late arrivals to scheduled appointments become a chronic occurrence, we reserve the right to cancel upcoming appointments. * We do also understand emergencies do happen and certain circumstances may be excluded from the above requirements. _____Initials