Simply Results
PHYSICAL THERAPY
Keeping you moving...getting you better!

Please Initial(_____) Acknowledgment of Privacy Notice Receipt:
For patient information, there is always in the waiting room a copy of the "Notice of Privacy Practices for Simply Results Physical Therapy, with an effective date of September 20, 2013" I understand that I may have a copy of the privacy notices at any time for my own files.

Please Initial(_____) <u>Informed consent for evaluation and to start physical therapy treatment today, for the use of Simply Results Physical Therapy's courtesy billing service, and acknowledgement of my responsibilities as a patient</u>:

The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy for me will be determined during the first visit and will be explained to me. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the evaluation, treatment and options available for my condition.

Potential risks: I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury. This discomfort is usually temporary; if it does not subside in 1-3 days, I agree to contact my therapist so that treatment can be adjusted accordingly.

Alternatives: If I do not wish to participate in the therapy program, I will say so to the physical therapist. Also, I will continue to discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

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

Cooperation with treatment: I understand that in order for therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent attendance. I agree to cooperate with and carry out the home program assigned. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

Please Initial(_____) Permission to leave message: I authorize the routine practice of leaving a message on my answering machine as needed, and/or sending a text, and/or sending an email to confirm my appointments or to relay other information as needed to coordinate care.

Please Initial(_____) Cancellation Policy: People on our waiting list are in pain and urgently need to be seen, and they also need time to make arrangements, so advanced notice is needed. On behalf of those in need of care, we respectfully request that you allow **<u>ONE WEEK ADVANCE NOTICE</u>** of any appointment changes to time or day.

Please Initial(_____) Health History Completed: I have informed my therapist of any condition that would limit my ability to have an evaluation or to be treated. I hereby request and consent to the evaluation and treatment to be provided by the therapists at Simply Results Physical Therapy.

Please Initial(_____) Plan of Care Agreement: My diagnosis, evaluation findings including the treatment program, the expected benefits or goals of treatment, and reasonable alternatives to the recommended treatment program, will all be explained by the PT as information is gathered. I am willing to ask questions about my care until my questions are answered to my understanding and satisfaction so I can consent to the recommended course of treatment. Returning for follow-up visits demonstrates agreement to the plan of care.

Please Initial(_____) Release of medical records/discuss with physician: I authorize the release of my medical records to my physicians/primary care provider or insurance company. The PT is allowed to discuss my medical condition with my referring physician, with the permission I assign today. Also, other records, from any other facility where I have been treated, are authorized for release.

Please Initial(_____) Assignment of Benefits and Release of Medical Information: I hereby authorize payment of medical benefits to SIMPLY RESULTS PHYSICAL THERAPY, INC for services rendered to my dependents or myself. I also authorize the release of any medical information that is necessary to process Medicare and/or insurance claims. I understand that I am responsible for any amount not covered by insurance within 60 days of service, and finance charges/fees will be assessed on overdue balances. I understand that a copy or facsimile of this authorization can be used in place of the original. This assignment will remain in effect until revoked by me in writing.

Patient Signature:_____Patient Name:_____
(Please Print)

Signature of Parent or Guardian (If applicable)_____

Witness Signature_____Date:_____