CONDITIONS & CONSENT FOR PHYSICAL THERAPY

I understand that I am a patient of Denise Alberto Physical Therapy Inc. My care is the exclusive responsibility of the therapist that I am assigned to. It may be Denise Alberto, MPT or Alexandra Blefari, DPT.

You are receiving direct physical therapy treatment services and may continue to receive direct physical therapy treatment services for a period of up to 45 calendar days or 12 visits, whichever occurs first, after which time a physical therapist may continue providing you with physical therapy treatment services only after receiving, a dated signature on the physical therapist's plan of care indicating approval of the physical therapist's plan of care and that an in-person patient examination and evaluation was conducted by the physician, chiropractor, surgeon or podiatrist.

Cooperation with treatment:

In order for physical therapy treatment to be effective, I must come to scheduled appointments unless there are unusual circumstances. I understand and agree to cooperate with and perform the home physical therapy program intended for me. If I have trouble with any part of my treatment program, I will discuss it with my therapist.

Cancellation Policy:

I understand that if I cancel more than 24 hours in advance, I will not be charged. I understand that if I cancel less than 24 hours in advance, I will pay a cancellation fee of $80.00. To be paid at the time of your next appt.

No warranty: I understand that there are no guarantees regarding a cure for or improvement in my condition. I understand that my physical therapist will outline and discuss goals of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

Informed consent for treatment:

The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to you. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the 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 or condition. This discomfort is usually temporary; **if it does not subside in 24 hours, I agree to contact my physical therapist.**

Potential benefits: I may see an improvement in my symptoms and an increase in my ability to perform 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.

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.

Release of medical records:

I authorize the release of my medical records to the following physicians/primary care provider or insurance company;

Financial and insurance responsibilities:

I agree to pay for my treatments at time of service, by cash, check, or Major Credit Card unless other mutually agreed upon arrangements have been made. I understand it is my responsibility to call my insurance company ahead of time, and obtain any pre-authorization that is necessary, and get an estimate of my benefits. I understand my therapist will provide me with a receipt on the same day of service that is my responsibility to submit to my insurance company.

I have read the above information and I consent to physical therapy evaluation and treatment.

Print Name _____ Date_____

Patient or guardian signature_____

Therapist signature_____ Date _____