Physical Therapy

Consent to Treat:

Physical therapy includes the examination, evaluation, and treatment of musculoskeletal related conditions. Treatment techniques may include the following: soft tissue mobilization, instrument assisted soft tissue mobilization (IASTM), joint mobilization, therapeutic modalities, exercise, education and consultation. The goal is to examine the impairments and causes for the limitations at hand to determine the best options to eliminate and/or reduce your symptoms and restore your optimal level of movement and activity.

One of the goals of physical therapy is to reduce symptoms including pain and swelling, however some increase in symptoms, such as soreness and bruising, may be a normal response to treatment, especially in the early stages, and should be discussed with the Physical Therapist. You are expected to fully communicate with the physical therapist regarding any change in your symptoms to ensure proper management which may require modifications to treatment necessary to achieve an optimal outcome.

I, the patient, understand the physical therapy and related services may not be a guaranteed solution to my issue but, to the best of my ability, I will do what is advised by my physical therapist as a home exercise program may be necessary on my part to see the full results. I understand I have other alternatives to treatment which can be discussed.

I, as the patient, understand the expectations, risks and benefits involved in physical therapy services. I understand I may ask any questions I have for further clarification, and have the right to refuse any component or all of the proposed treatment.

_____ **I agree**
[Initial]

Privacy Policy:

I authorize Stronger Performance Physical Therapy LLC to obtain my medical and contact information provided in the patient intake form and through other methods of appropriate communication when necessary.

I authorize Stronger Performance Physical Therapy LLC to communicate and release my records in physical therapy to my appropriate health care professionals if needed as the State of New Jersey Direct Access laws encourage the patient's medical doctors to be informed of their treatment in physical therapy if the duration exceeds 30 days.

I understand any personal information that I provide to Stronger Performance Physical Therapy LLC is confidential and will only be disclosed to third parties if authorized by me, the patient.

_____ **I agree**
[Initial]

Payment/Billing Policies:

Payment shall be due at the time of service in accordance with the fee schedule provided. Fees are subject to change upon 60 days written notice. Payment for each individual session is nonrefundable. You may purchase discounted packages of sessions which do not expire. If the use of discounted packages is discontinued, any purchased packages will be honored. If you purchase a discounted package of sessions, the purchase may be refunded up to 7 days after purchase. Thereafter, no refunds of the discounted sessions will be available.

As Stronger Performance Physical Therapy LLC is out of network with insurance companies, we will not bill your insurance. Upon request, we can provide you with a superbill which you can submit to your insurance company for potential reimbursement, depending on your plan, however this will be your responsibility.

Stronger Performance Physical Therapy LLC accepts cash (full amount), check, credit/debit cards, and HSA/FSA cards. Any rejected payment for insufficient funds or other rejection shall result in a service of $25.00 in addition to the outstanding payment.

_____ **I agree**
[Initial]

Cancellation/Late Policy:

If you must cancel or reschedule your appointment, please do so within 24 hours of the start of the appointment time. If you provide less than 24 hours' notice, you take away the opportunity for another patient to be scheduled for that time. A late cancellation/reschedule, or no-show fee of $50 will be charged.

If you are late for your appointment your treatment session duration may be reduced to eliminate the inconvenience of the patients to follow. It is the therapist's discretion to determine if there is sufficient time remaining to complete a session or if it will need to be rescheduled, however the patient will still be charged for the full session which was scheduled.

_____ **I agree**
[Initial]

General Acknowledgment:

_____I agree that all the information provided to Stronger Performance Physical Therapy LLC through all forms and communication is accurate to the best of my knowledge.

_____ I acknowledge that I received and have read all of the policies and procedures and have asked any questions I have prior to signing this form.

_____ I acknowledge that part or all of my treatment may be located in an open/non-private environment (i.e. a gym) and understand that some of my information may be overhead by others although will be minimized at every attempt. If I want a private environment I understand I may request it but understand that the schedule for services may change to accommodate the private location requested.

X_____ _____

Patient's signature **Date**

_____

Print Name

If patient is a minor:

X_____ _____

Signature of Guardian **Date**

_____

Print Name

Photo/Video Consent (OPTIONAL):

The use of photos and videos for physical therapy is often useful to show a patient progress that is being made as well as to offer a visual aid in assisting a patient to modify how they engage with a certain modality. In addition, use of photos and videos can assist prospective patients to see the use and benefits of certain exercises and treatment options available. While every patient is different and the therapy is determined based upon the individual issues presented, treatment techniques may be similar for multiple patients.

I understand the photos and videos may be taken but shall only be used based upon my express agreement.

_____ **I agree** to the taking of photos and videos for use in my physical therapy.

_____ **I agree** to the use of photos and videos of me to be used in advertising for potential patients to see the benefits of physical therapy and treatment techniques. Any such use for advertising will refer to my first name only, the initial issue for which you sought treatment in general terms, i.e., shoulder pain, and the end result. No personal and/or medical information would ever be used or disclosed. I understand that absent my specific agreement, no photo or video of me may be used in any form of advertising.

OR:

_____ **I disagree**

X _____ _____

Patient's signature **Date**

_____

Print Name