Personal Physical Therapy Services

Personal Issues... Personal Care

Conditions and Consent

1. **Cooperation-** I understand that in order for physical therapy to be effective, I need to come as scheduled. I agree to cooperate with and carry out the home physical therapy program that was specifically designed for me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

2. **Late Fee-** I understand that I may be billed a $25 late cancellation if I cancel less than 24 hours in advance or if I fail to show up for a scheduled appointment.

3. **Grounds for Discharge-** I understand that if I cancel or miss 3 scheduled visits, unless discussed with the physical therapist, I may be discharged from physical therapy and my doctor will be notified.

4. **No Warranty-** I understand that Personal Physical Therapy Services, LLC and Jennifer A Thibodeau, PT cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that Jennifer Thibodeau, PT will share with me her opinions regarding potential results of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

5. **Informed Consent for Treatment**

The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to me. The physical 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 understand 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: May include an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements and activities. I may experience a decrease in 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.

I have read the above information and I consent to physical therapy evaluation and treatment. By signing below, I acknowledge that I have read, understood and will abide by the conditions and policies noted on this consent form.

_____ _____

Print Name Date

_____ _____

Patient's Signature PT Signature / Date