ReSculPT Physical Therapy and Wellness

Informed Consent

Patient Name: _____ Date of Birth: _____

1. Consent for Physical Therapy Services

The purpose of physical therapy services is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis and intervention through the use of therapeutic procedures, mobilization, massage, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities.

Response to physical therapy intervention varies from person to person; hence, I understand it is not possible to accurately predict my response to a specific modality, procedure or exercise protocol. I further understand that it is my right to decline any part of treatment at any time before or during treatment should I feel any discomfort or pain or have any unresolved concerns. It is also my right to ask my physical therapist about the treatment they have planned based on my individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, it is my right to discuss the potential risks and benefits involved in my treatment.

I have read this consent form and understand the risks involved in physical therapy. I agree to fully cooperate, participate in physical therapy procedures and comply with the established plan of care. My signature below certifies that I have read and understand the above information regarding informed consent.

2. Release of Information, Assignment of Benefits and Financial Responsibility

I give permission to ReSculPT Physical Therapy and Wellness to release information, written and verbal, contained in my medical record, and other related information, to my insurance company, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries as it relates to my treatment and/or payment for services provided. I authorize ReSculPT Physical Therapy and Wellness to obtain medical records and/or professional information as it relates to my treatment and/or medical benefits.

I agree to pay any applicable co-payments or co-insurance as applicable at the time of service. I understand that my insurance benefits may not cover all charges and that I am responsible for those charges not covered by my health insurance or third-party payer. I understand and agree that if I fail to make payments for which I am responsible for in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

Patients may opt out of using insurance coverage at any time. Cash payments are accepted in the form of cash, check or credit card and are due at time of service.

I authorize payments directly to ReSculPT Physical Therapy and Wellness of medical benefits and/or insurance reimbursements for services rendered. This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original. My signature below

certifies that I have read and understand the above information regarding release of information and assignment of benefits.

3. Notice of Health Information Privacy Practices Acknowledgement

I acknowledge that I have received a copy of the Notice of Health Information Privacy Practices. I hereby consent to the use and disclosure of my personal health information for the purposes of treatment and payment.

4. Disclosures to Specific Family Members and/or Friends

I direct ReSculPT Physical Therapy and Wellness to disclose protected health information to the individuals named below for purposes of allowing these individuals to participate in my care and to understand my health condition and treatment options:

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

5. Attendance and Cancellation Policy

I understand the importance of timely attendance of my therapy sessions in order to maximize the benefits of physical therapy treatment. I agree to provide at least 24 hours' notice when I need to cancel or reschedule an appointment. I understand that I may be rescheduled if I arrive more than 15 minutes late for my scheduled appointment.

Repeated cancellations, no-shows or late attendance prevent other patients from utilizing this appointment time and hinders your own rehabilitation program. We reserve the right to discontinue physical therapy services at ReSculPT Physical Therapy and Wellness due to repeated cancellations, no-shows or late attendance per the discretion of the physical therapist.

A cancellation or no-show fee of $50 will be charged if notice is not provided 24 hours in advance. ***No refunds will be provided. Potential credits towards other Elite therapies will be provided if warranted.***

6. Consent to Email Notification

ReSculPT Physical Therapy and Wellness offers patients the opportunity to communicate via email. Transmitting patient information by email has a number of risks associated that should be considered before using email as a form of communication.

ReSculPT Physical Therapy and Wellness will use reasonable means to protect the security and confidentiality of email information sent and received; however, due to risks associated with email use, ReSculPT Physical Therapy and Wellness cannot guarantee the security and confidentiality of this form of communication. We will not be liable for improper disclosure of confidential information that is not caused by ReSculPT Physical Therapy and Wellness' intentional misconduct. Thus, the patient must consent to communicate via email under the following conditions:

A. **All emails to or from the patient concerning diagnosis or treatment may be included in the patient's medical record. Other individuals who are authorized to access the medical record may have access to these emails.**

B. **ReSculPT Physical Therapy and Wellness may forward emails internally to other staff as necessary for diagnosis, treatment, reimbursement or other handling. We will not forward emails to independent third parties without the patient's prior written consent, except as authorized or required by law.**
C. **ReSculPT Physical Therapy and Wellness cannot guarantee the timeframe in which emails are read and responded to; therefore, patients shall not use email as a form of communication for medical emergencies or other time sensitive communications.**
D. **The patient is responsible for information ReSculPT Physical Therapy and Wellness of any types of information the patient does not want to be sent by email.**

SIGNATURE FOR CONSENT:

By my signature below, I acknowledge that I have ready, understand and agree to the terms and conditions contained in the sections above.

Printed Name of Patient/Legal Guardian: _____

Signature of Patient/Legal Guardian: _____ Date: _____

Relation to Patient: _____