Consent to Treat

As a patient you have the right to be informed about your health condition(s) and about recommended rehabilitation treatments. This document provides information that you may use for the purpose of deciding to give or to withhold your consent to be provided with care at Advanced Therapy and Performance.

I, _____, request and consent to examination and treatment for Physical Therapy and/or wellness consultation and/or physical training. I further understand that I have the right to ask questions about the following

- All aspects of examination and treatment, my condition, diagnosis or prognosis
- The constructed goals and potential benefits of any proposed care
- Inherent risks, complications, or side effects of a specific treatment
- The likelihood of improvement or success following a specific intervention
- Reasonable, available alternatives to the suggested care and character of treatment

Potential risks I may experience include 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 an associate of Advanced Therapy and Performance.

Potential benefits I may experience include an improvement in my symptoms and an increase in my ability to perform movement and daily activities. I may experience increased strength, awareness, flexibility and endurance with activity. I may experience decreased pain and discomfort. I will learn strategies for managing my condition and resources available to me will be shared.

If I do not wish to participate in a recommended program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider. It is anticipated that any recommendations, intervention and/or exercise program is intended to improve my health and well-being.

FEE FOR SERVICE PRACTICE I have reviewed the clinic fees and understand that I am responsible for payment at the time of service. I understand it is my responsibility to call my insurance company ahead of time, obtain any pre-authorization that is necessary, and get an estimate of my benefits. I understand that upon written request my therapist will provide me with a receipt (Superbill) that is my responsibility to submit to my insurance company if desired. I understand that I will not be able to submit for reimbursement by Medicare. If you are billing through a PIP claim (motor vehicle accident) and those funds run out, you will be responsible for the remaining cost of physical therapy.

Printed name:_____

Signed name:_____

Date:_____