PHYSICAL THERAPY INFORMED CONSENT AND AGREEMENT

Patient Name: Date of Birth:

Introduction:

This Physical Therapy Informed Consent and Agreement (the "Agreement") is entered into by the undersigned patient ("Patient") and the physical therapy provider ("Provider"). The purpose of this Agreement is to explain important information about the physical therapy services, risks, benefits, and patient responsibilities in compliance with applicable United States law.

Consent for Treatment:

I voluntarily consent to receive evaluation, examinations, and physical therapy treatment as deemed necessary by my Provider. I understand that physical therapy involves hands-on treatment, exercises, use of equipment, modalities, and other therapeutic procedures. I acknowledge that no guarantees have been made regarding the outcome of my treatment.

Potential Risks and Benefits:

I understand that physical therapy carries some risks, which may include, but are not limited to, temporary soreness, pain, swelling, bruising, or aggravation of preexisting conditions. Rare but serious risks can include injury or worsening of conditions. I understand that the benefits include improved physical function, pain relief, and enhanced quality of life.

Patient Responsibilities:

I agree to provide accurate and complete medical history and to inform my Provider of any changes in my health status. I will follow prescribed treatment plans, attend scheduled appointments, and communicate any concerns or adverse reactions promptly. I understand that failure to participate or follow instructions may limit treatment effectiveness.

Privacy and Confidentiality:

I acknowledge that my personal health information will be handled in accordance with applicable privacy laws including HIPAA. I consent to the use and disclosure of my information for treatment, payment, and health care operations.

Financial Responsibility:

I understand that I am financially responsible for all charges for services provided that are not covered or paid by my insurance or other third-party payer.I agree to promptly pay any balances due according to Provider's billing policies.

Cancellation and No-Show Policy:

I understand that missed appointments or late cancellations may result in fees and may affect my treatment plan.

Liability Release:

I release Provider and its employees from any liability for injury or harm arising from the provision of physical therapy services except for negligence or willful misconduct. This release is binding to the fullest extent permitted by law.

Termination of Treatment:

I acknowledge that I may terminate treatment at any time and that Provider may terminate treatment for failure to comply with this Agreement or Provider policies.

Acknowledgement and Signature:

I acknowledge that I have read and understand this Agreement, that I have had the opportunity to ask questions, and that I voluntarily consent to physical therapy treatment under the terms described herein.

Patient Signature	**Provider Signature**
Signature: _____	Signature: _____
Printed Name: _____	Printed Name: _____
Date: _____	Date: _____