



Physical Therapy Consent Form

Consent: I consent to and authorize Spine and Sports Physical Therapy (including students in training) to administer physical therapy treatment under the direction and supervision of the physical therapist. I understand and am informed that, as in the practice of medicine, physical therapy may have some risks. I understand that I have the right to ask about these risks and have any questions about my conditions answered prior to treatment. I know it is up to me to inform the physical therapist/staff about any health problems or allergies I have, as well as medications I am taking.

Minor Patients: The parent or guardian accompanying a minor is responsible for payment of services. Unaccompanied minors (under 18) will be denied non-emergency treatment, unless the parent or guardian has signed patient and financial responsibility forms. Parents should remain present with their child during treatment or at least be immediately available for communication upon request.

Release of Information: SSPT releases patient health care information for purposes of treatment or payment, or to other health care organizations, as explained in our HIPAA Notice of Privacy Practice. I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.

No Guarantees: I understand that the practice of physical therapy is not an exact science and that no guarantees have been made to me as a result of treatments or examinations by the physical therapist or supportive staff. I understand that no contract, guarantee, warranty, or promise concerning the results of the physical therapy services is made.

Collections: If your account becomes delinquent, collection proceedings will occur and you will be 100% liable for any collection fees, attorney and court costs incurred by SSPT to collect said fees from the Responsible Party.

No Show/Cancel/Late Policy: Cancellations with less than 12 hours notice will result in a \$10.00 fee. If you arrive late for your appointment, the therapists may not have the time to treat you or your therapy time may be reduced.

The undersigned patient or Responsible Party acknowledges that he/she has read and agrees to the information presented above.

Client Name: (please print) _____

Client Signature: _____ Date: _____

Parent / Guardian Signature: _____ Date: _____