Informed Consent

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Conditions & Consent for Physical Therapy

I understand that I am a patient of BeneFIT Physical Therapy LLC, a private, therapist owned Physical Therapy practice.

Cooperation with Treatment In order for Physical Therapy treatment to be effective, I must come to scheduled appointments unless there are unusual circumstances. I understand and agree to cooperate with and perform the home Physical Therapy program intended for me. If I have trouble with any part of my treatment program, I will discuss it with my Physical Therapist.

Cancellation Policy I understand that to successfully achieve the goals of treatment established by myself and my physical therapist it is essential for consistent attendance as outlined by my plan of care. I understand that three (3) no shows could result in my discharge from therapy. Furthermore, I understand that if i cancel more than 12 hours in advance I will not be charged. I understand that if I cancel in less than 12 hours in advance I will pay a cancellation fee of $25.00. To be paid at the time of my next appointment.

Limitations I understand that there are no guarantees regarding a cure for, or improvement in my condition. I understand that my Physical Therapist will outline and discuss goals of physical therapy treatment for my condition and will discuss treatment options with me before i consent to treatment. There may be times where my insurance company will withhold payment for certain services rendered but care will be taken to inform me of such circumstances prior to rendered services.

Informed Consent for Treatment I understand the term 'informed consent' means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to me. The 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 I understand i may experience an improvement in my symptoms and an increase in my ability to perform daily activities. I may experience increased strength, awareness, flexibility, and endurance in my movements. I may experience decreased pain and discomfort. I can expect to gain a greater knowledge about managing my condition and the resources available to me.

Alternatives I understand that 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.

Financial and Insurance Responsibilities i understand it is my responsibility to call my insurance company ahead of time to obtain any pre-authorization that is necessary, and to obtain verification of my outpatient physical therapy benefits. I understand BeneFIT Physical Therapy LLC will call my insurance carrier as a courtesy for me but ultimately it is my responsibility to verify the information BeneFIT Physical Therapy LLC receives is accurate. If I have any questions regarding my insurance coverage I understand that I can ask my insurance carrier, my therapist, or BeneFIT Physical Therapy LLC for further assistance.

Notice of Privacy Policies I understand that I was provided with a copy of the Notice of Privacy Policies utilized by BeneFIT Physical Therapy LLC in compliance with regulations under the Health Insurance Portability and Accountability Act (HIPAA) Sec. 45 CFR 160 and 164. I understand that if I would like more information about BeneFIT Physical Therapy LLC's privacy practices or to file a complaint I can contact BeneFIT Physical Therapy attn: privacy Officer at 479 Union Ave Bridgewater NJ 08807.

I have read the above information and I consent to the Physical Therapy Evaluation and all subsequent treatment.

_____ _____
Print Name Date

_____ _____
Patient/Parent(Guardian) Signature if patient is under 18 years of age Witness