Prime Physical Therapy
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Lee's Summit, MO 64086
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Informed Consent for Physical Therapy Services

Informed Consent for Treatment: The term "informed consent" indicates that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to me. I understand that the physical therapist offers a wide range of services and I will receive information at the initial visit regarding the treatment and options available for my condition(s). I will notify my practitioner if I am pregnant and/or have significant medical conditions. I understand I am encouraged to communicate with a physician the potential benefits and risks of treatment relevant to my pregnancy and/or other significant medical conditions that are not in the scope of physical therapy.

Potential Benefits: Benefits may include an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resourses available to me.

Potential Risks: I may experience an increase in my current level of pain or discomfort, or aggravation of my existing injury during physical therapy. This discomfort is usually temporary; if it does not subside in 24-48 hours, I agree to contact my physical therapist.

No Warranty: I understand that my physical therapist cannot make any promises or guarantees regarding a cure for or improvements in my condition. I understand that my physical therapist will share with me her opinions regarding potential results of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

Alternatives: 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.

Insurance: I, the patient, am ultimately responsible for payment of my account. As a courtesy, Prime Physical Therapy will bill my insurance company on my behalf. I am responsible for paying any deductible and/or co-payment due at time of service. After 60 days any balance not paid by insurance will become my responsibility.

Cash Payer: I may elect to pay out of pocket for physical therapy services. For patients without insurance or for those who elect to pay out of pocket, a discounted "cash rate" of $150 for the initial evaluation and $89 for follow-up appointments will apply. Payment will be due at the time of service.

Cancellation Policy: In the event that I need to cancel a scheduled appointment, I agree to provide the courtesy of 24-hours notice so that Prime Physical Therapy can offer my appointment to patients waiting on the standby list. If I fail to give 24-hours notice of a cancellation more than two times, I understand that I will be subject to discharge from Prime Physical Therapy.

I have read the above information and I consent to physical therapy evaluation and treatment. My signature below acknowledges that I have read, understood and will abide by the conditions and policies noted on this consent form.

_____ _____

Print name of patient Date

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Patient's signature (if patient is a minor, parent or legal guardian must sign)