CONDITIONS & CONSENT FOR PHYSICAL THERAPY
I understand that I am a patient of AC Physical Therapy PC, LLC, a 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 therapist.
Cancellation Policy
I understand that if I cancel more than 24 hours in advance, I will not be charged. I understand that if I cancel less than 24 hours in advance, I will pay a cancellation fee of $ 50.00 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:
The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to you. 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 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:
Benefits may include 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:
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.
Release of medical records:
I authorize the release of my medical records to my physicians/primary care provider and/or insurance company.
Financial and insurance responsibilities:
I understand it is my responsibility to call my insurance company ahead of time, and obtain any pre-authorization that is necessary, and get an estimate of my benefits. ACPT will also call my insurance company for a listing of benefits. If I have questions regarding my insurance coverage I understand that I can ask my insurance company, therapist or office manager for further assistance. In the event that my insurance is not contracted with ACPT I will be informed of my options for out of network benefits or cash pay. In such, I understand my therapist will provide me with a receipt on the same day of service that is my responsibility to submit to my insurance company.

I have read the above information and I consent to physical therapy evaluation and treatment.

Print Patient Name _____ Date _____

Patient Signature_____

Signature of legal guardian if patient is under 18 _____

A copy of this consent form is available; please ask the receptionist if you would like one.