Transcend PHYSICAL THERAPY

Orthopedics Sports Medicine Women's Health

To triumph over the negative or restrictive aspects of…

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CONDITIONS & CONSENT FOR TRANSCEND THERAPY

I understand that I am a patient of Paula Merchant, PT who is an independent Physical Therapy practitioner at Transcend Therapy, LLC.

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 the cancellation policy for this clinic is a 24 hour notice. This enables others to have the opportunity to specific appointment times. I understand that there could be an associated cancellation fee of $25 in certain circumstances in which less than 24 hours notice is given.

No warranty: 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.

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: I 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 should 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 the following physicians/primary care provider or insurance company;

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Financial and insurance responsibilities:
I agree to pay for my treatments at time of service, by cash, check, or charge card unless other mutually agreed upon arrangements have been made. 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.

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

_____ _____

Print Name Date

_____ _____

Patient or guardian signature Therapist signature / Date