Conditions and Consent for Treatment

As a patient you have the right to be informed about your health condition(s) and about recommended rehabilitation treatments. This document provides information that you may use for the purpose of deciding to give or to withhold your consent to be provided with care at Thrive HQ.

I, _____, request and consent to examination and treatment for Physical Therapy and/or personal training. I further understand that I have the right to ask questions about:

- All aspects of examination and treatment, my condition, diagnosis or prognosis
- The nature or goals and potential benefits of any proposed care
- The inherent risks, complications, or side effects of treatment
- The likelihood of improvement or success following intervention
- Reasonable, available alternatives to the suggested care and character of treatment

Potential risks I may experience include 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 therapist. Potential benefits I may experience include an improvement in my symptoms and an increase in my ability to perform movement and daily activities. I may experience increased strength, awareness, flexibility and endurance with activity. I may experience decreased pain and discomfort. I will learn strategies for managing my condition and resources available to me will be shared.

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. It is anticipated that physical rehabilitation will allow improved function through decreased pain, increased strategies for managing pain, weakness, or immobility.

Fee For Service Practice

I have reviewed the clinic fees and understand that I am responsible for payment at the time of service.

I understand it is my responsibility to call my insurance company ahead of time, obtain any pre-authorization that is necessary, and get an estimate of my benefits.

I understand that upon a written request my therapist will provide me with a receipt (Superbill) that is my responsibility to submit to my insurance company if desired.

I understand that I will not be able to submit for reimbursement by Medicare.

Printed name: _____

Signed name: _____ Date:_____