MOBILE HEALTH
PHYSICAL THERAPY

CONSENT FOR TREATMENT

Patient's Name_____ **DOB**_____

Parent's/Guardian's Name (if applicable) _____

Welcome to Mobile Health Physical Therapy. It is an honor you have chosen me to guide you through your rehabilitation process.

Please read and initial each item below, then sign at the bottom.

_____ I certify that I am requesting the services of Mobile Health Physical Therapy for myself or my child, for the purposes of physical therapy assessment, treatment, and recommendations. I understand that physical therapy often involves the use of manual techniques that require appropriate physical contact by the health care provider and staff.

_____ I understand that there are no guarantees regarding a cure for or improvement of 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.

_____ I understand that I may experience a potential increase in my current level of pain or discomfort, or an aggravation of my existing injury or condition. This increase in discomfort is usually temporary; if it does not subside in a reasonable time period, I agree to contact my physical therapist.

_____ I certify that I have been advised of my HIPPA health information rights to privacy and confidentiality. I understand that these rights be will respected and upheld.

_____ I understand that my services and/or treatment with Mobile Health Physical Therapy may be terminated in the case of non-compliance. This includes repeatedly missing/canceling appointments, failure to pay the fees for services rendered and determined as obligatory by my insurance and the guidelines of this practice.

_____ _____

Patient or Parent/Guardian Signature Date

_____ _____

Witness Signature Date