CONDITIONS & CONSENT FOR PHYSICAL THERAPY

_____ I understand that I am a patient of Kate Biles, PT, DPT who is an independent Physical Therapy practitioner working at 280 N. Phoenixville Pike, Malvern PA.

_____**Cooperation with treatment:**
I understand that in order for physical therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from attending therapy. I agree to cooperate with and carry out the home physical therapy program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

_____**Cancellation Policy**
Please take into consideration that my clinic hours are limited and there are often patients on my waiting list.
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 late cancellation fee of $75.00. If I fail to come to a scheduled appointment without giving any notice, I will be charged the full amount of the session.

_____**No warranty: I understand that Kate Biles, PT, DPT cannot make any promises or guarantees regarding a cure for or improvement in my condition.** I understand that Kate Biles, PT, DPT 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.

Informed consent for treatment:
The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to me. 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 understand I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my physical therapist.
_____**Potential 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 resources available to me.
_____ **Pelvic Floor Rehabilitation**: I understand that evaluation and treatment of pelvic floor dysfunction will consist of internal examination and also internal treatment of the pelvis. The pelvic floor muscles can be reached both vaginally and rectally. Kate will explain to me in detail what will happen and my questions will be answered so that I am comfortable with the evaluation and treatment. I also understand that Kate practices alone and does not have another person in the room. I will bring someone with me if I would be more comfortable with a chaperone.
_____**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 or insurance company. Please list.

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Financial and insurance responsibilities:
_____ I agree to pay for my evaluation and treatments at the time of service, by cash or check, 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 understand my therapist will provide me with a receipt 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. By initialing above and signing below, I acknowledge that I have read, understood and will abide by the conditions and policies noted on this consent form.

____ ____________________
Print Name Date

____ ____________________
Patient's signature Therapist Signature / Date
(if minor, parent or legal guardian must sign)