PT NORTHWEST

Conditions of Service

Consent to Rehabilitation Services: The term "informed consent" means that the potential risks, benefits, and alternatives of therapy evaluation and 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 evaluation, 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. This discomfort is usually temporary; if it does not subside in 1-3 days, I agree to contact my therapist.

Potential Benefits: I may experience 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.

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.

Cooperation with treatment: I understand that in order for 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 program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

Pediatric Disclaimer: I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.

No Warranty: I understand that the therapist cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my therapist will share with me their opinions regarding potential results of therapy treatment for my condition and will discuss all treatment options with me before I consent to treatment.

I will inform my therapist of any condition that would limit my ability to have an evaluation or to be treated. I hereby request and consent to the evaluation and treatment to be provided by the therapists at PT Northwest.

INITIAL_____

Authorization, Assignment and Guarantee of Payment: I acknowledge that I have provided complete and accurate information, including name, address, phone number and insurance information, allowing PT Northwest to act as my billing agent for services rendered. The undersigned below agrees to assign PT Northwest all insurance benefits available for any clinical services rendered, which will be paid directly to PT Northwest. I have received a copy of and agree to the PT Northwest Financial Policy. If payment creates a financial hardship, I understand I may inquire about assistance by contacting the PT Northwest Billing Office.

INITIAL_____

Privacy Notice: I acknowledge PT Northwest will use my information for the purposes of treatment, payment, and health care operations. I understand that if I have questions or complaints I may contact the Privacy Officer.

I acknowledge that I have been given or have waived my right to review the Notice of Privacy Practices. **INITIAL**_____

I acknowledge that I have been given or have waived my right to review the Statement of Patient Rights **INITIAL**_____

No Show/Cancellation Policy: I acknowledge that I have received a copy of the PT Northwest No Show/Cancellation Policy and agree to all terms set forth within.

INITIAL_____

I have read and understand the above information, have asked questions about anything I do not understand and I am satisfied with the answers I received. I acknowledge that the information I have given is true and accurate to the best of my knowledge. I understand I may revoke my consent in writing at any time, but action taken by PT Northwest before that time will remain covered by this form.

X_____

Patient or Patient's Representative **Signer's Relationship to Patient** **Date**

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Signature of Witness - PT Northwest Staff