restore physical therapy
541-908-7959 ptrestore@gmail.com 966 NW Circle Blvd. Corvallis, OR 97330

CONDITIONS & CONSENT FOR PHYSICAL THERAPY

PLEASE FILL OUT and BRING WITH YOU to your first appointment.

COOPERATION WITH TREATMENT:

I understand that in order for physical therapy treatment to be effective, I must come to scheduled appointments unless there are unusual circumstances that prevent me from attending therapy. 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.

NO WARRANTY:

I understand that the physical therapist cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my physical therapist will share with me opinions and available statistics and studies regarding 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 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: You may experience an increase in your current level of pain or discomfort, or an aggravation of your 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: May include an improvement in your symptoms and an increase in your ability to perform daily activities. You may experience increased strength, awareness, flexibility and endurance in your movements. You may experience decreased pain and discomfort. You will have greater knowledge about managing your condition and the resources available to you.

Alternatives: All physical therapy treatment options available to your conditions will be explained to you. You may inquire about the cost of these services and discuss them with your therapist. If you do not wish to participate in the therapy program, you may discuss your medical, surgical or pharmacological alternatives with your primary care physician.

FINANCIAL AND INSURANCE RESPONSIBILITIES:

I agree to pay for my treatments at time of service, by cash, check, or credit 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 understand my therapist will provide me with a receipt and that it is my responsibility to submit to my insurance company.

I have read the above information and I consent to physical therapy evaluation and treatment. I have asked any questions and they have been answered to my satisfaction. I understand the risks, benefits and alternatives to treatment. I hereby voluntarily consent to physical therapy treatment. I understand that I may choose to discontinue treatment at any time.

_____ _____

Patient Signature Date

_____ _____

Guardian signature (if applicable) Therapist signature / Date

restore physical therapy
541-908-7959 ptrestore@gmail.com 966 NW Circle Blvd. Corvallis, OR 97330

PATIENT INFORMATION and FINANCIAL POLICY

PLEASE FILL OUT and BRING WITH YOU to your first appointment.

Kerry Boysen, PT is not a preferred provider for insurance companies. Instead, Restore Physical Therapy, LLC is a cash-based practice. By not having a preferred provider/contracted status with the insurance companies, the therapist does not have to limit the time or quality of treatment provided secondary to insurance company restrictions or elevate clinic rates to pay for billing services.

Prior to your first scheduled appointment, call your insurance company to completely understand your physical therapy benefits. You may complete the Insurance Benefits Worksheet (on the website) to help you ask the insurance company the right questions about your physical therapy benefits. At the time of service and payment, you will receive a written statement which you can submit to your insurance company for their consideration of reimbursement to you. Restore Physical Therapy will be happy to provide chart notes or other documentation at your (or your insurance company's) request. The amount of reimbursement you receive will vary according to the terms of your insurance policy. Some companies may reimburse you at 80%, some at 60%, some at 40%, and some may not reimburse you at all. Restore Physical Therapy cannot make guarantees or estimates regarding what reimbursement your plan allows.

Medicare Patients: Restore Physical Therapy does NOT accept Medicare and patients cannot be reimbursed by Medicare for visits at this clinic.

Restore Physical Therapy, LLC accepts cash, check or credit card at the time of service. Rates are based on time spent with you and the treatments performed during your appointment. The rates are as follows:

$ 150.00 for Initial Evaluation
$ 120.00 for 60 minute follow-up
$ 90.00 for 45 minute follow-up
$ 60.00 for 30 minute follow-up

CANCELLATION/NO SHOW POLICY

We are entering into a cooperative partnership to help you attain your maximal physical therapy goals. It is understandable that circumstances may arise which cause you to cancel your appointment. However, cancellations have a serious impact on the clinic. Cancellations more than 24 hours in advance will not be charged. Cancellations less than 24 hours in advance will pay a cancellation fee of $75. If you need to cancel a Monday appointment, you must notify the clinic by 4:00pm on Friday to avoid the cancellation fee. Cancellations within 2 hours of your scheduled appointment time will be charged for the full amount of your scheduled appointment.

By signing this document I agree to these conditions:

_____ _____
Patient Signature Date

_____
Printed Name