DIRECT IMPACT PHYSICAL THERAPY
PATIENT CONSENT FORM

Informed Consent:

I, _____, give the physical therapists of Direct Impact PT my personal consent to evaluate, treat, and create an individualized treatment plan for me based on their findings and my physical therapy diagnosis. I understand that a physical therapy diagnosis is not a medical diagnosis by a physician and that I will not be able to seek reimbursement from my medical insurance. I understand that it is my right to accept or refuse any treatment offered and that there are no guarantees made as to the results that may be obtained from the treatment(s). I understand the term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to me. I understand that I will receive education regarding the diagnosis, treatment, and prognosis including anticipated goals at the initial visit. I will also explain my plan of treatment and options available for my conditions at that time.

Use and Disclosure of Health Information / Privacy Practices:

I understand that my health information will only be used or disclosed by Direct Impact P.T. for the purpose of treatment, obtaining payment, or supporting the health care operations of the practice, including any administrative operations related to treatment or payment. Direct Impact P.T. may use my email to send occasional company newsletters pertaining to relevant medical news, deals, or promotions. Email addresses will never be used by or given to 3rd parties for use outside of Direct Impact P.T. I understand that I may opt out at any time.

Medicare and Insurance Company Notice:

Direct Impact P.T. has ***NO*** relationship with Medicare and therefore cannot accept out-of-pocket payments for services that would *normally be covered by Medicare*. I also understand that Direct Impact P.T. is a 100% cash based practice and does not deal with any insurance companies.

Payment:

I understand that I am responsible to pay cash or credit at the time service is rendered. If at any point payment for service is not paid at the time of treatment, I understand that Direct Impact PT has the right to terminate any subsequent visits. ***Cancellation of a scheduled appointment must be done at least 24 hours prior to appointment time to avoid a fee consisting of the full cost of the treatment session***.

Credit Card:_____

Credit Card Number: _____**Exp**:_____**CVV**:_____

I have reviewed this consent form and acknowledge that the information I provided is true and that I agree to the terms outlined. I certify that I am not a Medicare beneficiary (see above.) I have been given the opportunity to review this form and ask any questions related to it. I give my permission to Direct Impact Physical Therapy to use and disclose my health information in accordance with this document.

Signature: _____ Date: _____

Please print your name: _____