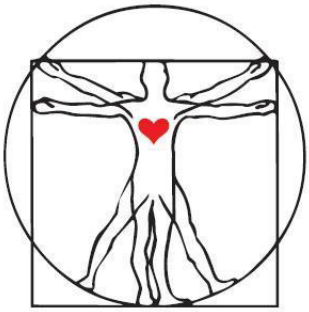

TEMPLE PHYSICAL THERAPY

Informed Patient Consent

TO OUR PATIENTS: It is our goal at Temple Physical Therapy to provide patients the highest quality healthcare services and to perform them within the highest ethical and legal standards. As such, we are required to explain your rights and responsibilities as a patient. If a question or concern arises about your care, please discuss this with your treating therapist. If your concern is unresolved, you may speak with the Office Supervisor or Director. Please carefully read and sign below.

CONSENT FOR TREATMENT: By signing this form, I consent to and authorize Temple Physical Therapy to evaluate me and provide treatment to improve my physical condition in the areas of pain reduction, range of motion, balance, strength or other physical impairments. I understand that my therapist is available to fully explain the purpose of the treatment and I have the right to refuse the recommended treatment.

RISKS: I am aware that there are certain risks involved with a therapy program including increased pain and swelling which may temporarily decrease my functional abilities. I understand that every effort is made to minimize risk by continuous professional assessments of my condition throughout my therapy.

RESPONSIBILITIES

I will inform my therapist *of any* changes in my medical condition, or medications, as they may necessitate a change in my therapy program.

I will stop any procedure or activity and inform my therapist of any symptoms of pain, fatigue, shortness of breath, dizziness or nausea that may develop during my treatment.

I will attend therapy sessions per the medical plan developed during my initial evaluation by my physician and therapist or cardiac rehabilitation physician as to the best of my abilities.

I am aware that if I arrive to any scheduled appointment greater than 15 minutes after the scheduled time, Temple Physical Therapy has the right to alter the treatment plan for that day.

If for any reasons I am unable to attend a therapy session, I will call to cancel at the earliest point in time.

I understand that, as a courtesy, TPT will verify my insurance coverage and will notify me of my co-payment or deductible amount and that it is payable at the time of visit. This is not a guarantee of payment by my insurance company and discrepancy in coverage is between me and my insurance company.

I will notify the front office of any changes in my insurance. If I neglect to do so, I understand that I may be liable for any fees incurred.

I understand that therapy may or may not improve my condition, but that every effort is being made to increase my pain free level of function. I have read, understood and agreed to the above listed categories.

_____ _____

Signature **Date**