HIPPA Acknowledgement

I acknowledge that I have received the attached Notice of Privacy Practices for Movement Physical and Occupational Therapy, LLC.

______________________________ ___________________________________

Patient Name (Printed) Patient or Representative Signature/Date

Cancellation and No-Show Policy

You are coming to therapy to improve the condition that is affecting you, therefore, it is absolutely necessary that you attend all of your scheduled appointments.

All missed appointments must be made up the same week, if available, so that you may fully recover.

Movement Physical and Occupational Therapy, LLC requires 24 hours advance notice for any cancellation. This enables us to fill your appointment.

______________________________ ___________________________________

Patient Name (Printed) Patient or Representative Signature/Date

Personal Representative’s relationship to patient (if applicable):_______________

Consent to Provide Care

Response to physical/occupational therapy intervention varies from person to person; hence it is not possible to accurately predict your response to a specific procedure, exercise protocol, or modality. Our staff does not guarantee what your reaction will be to care, nor do they guarantee that the treatment will resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that treatment may result in aggravation of existing symptoms.

It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain, or have other unresolved concerns. It is your right to ask the therapist about the treatment they have planned based upon your individual history, diagnosis, or symptoms. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

I have read this consent form and understand the potential risks involved in physical/occupational therapy. I understand that the success of my treatment depends on my ability and willingness to cooperate and participate in all physical/occupational therapy procedures and comply with the established plan of care.

______________________________ ______________________________

Patient Name (Printed) Patient or Representative Signature/Date

Personal Representative's relationship to patient (if applicable):______________

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