CPT physical therapy occupational therapy ...with a smile:)

Dear Patient,

Thank you for choosing CPT for your physical and occupational therapy needs! As a health care service provider, we realize that you DO have a choice for your care – and we are honored that you have chosen us!

To prepare for your first visit and initial examination, we would like to provide you with some information and helpful hints. The healthcare system can be challenging to navigate – and we hope that this helps to take some of the guesswork out of the process.

What should I wear to my appointments?
We recommend you wear comfortable clothing. If we will be addressing issues with a particular body part such as your knee or shoulder, it would be helpful to wear clothing that allows "easy access" to that region. Part of your examination may include "palpation" or touching of the injured area.

Can I have someone accompany me for the initial examination?
We understand that medical appointments can sometimes be overwhelming and having a friend or family member who knows you well can be helpful. We will do our best to accommodate any such request. With COVID-19, we reserve the right to restrict non-patient visitors from the treatment areas if we determine social distancing cannot be maintained.

Can I have someone accompany me for my treatment sessions?
During COVID-19, we are respectfully asking all non-patient visitors to wait in their vehicles. This is for the protection of all patients and our staff. Under pre-approved circumstances, a non-patient visitor may accompany a patient. In doing so, the safety and privacy of other patients cannot be compromised.

Will my insurance cover the cost of my therapy?
There are many insurances and even more insurance policies out there with different levels of coverage. Our front desk administrator will ask for your insurance card(s). Your insurance card will be copied, and we will call your insurance company on your behalf to verify your benefit eligibility and any out of pocket costs to you. It is important that you present ALL insurance information on the first day.

What if I cannot afford the out-of-pocket costs associated with my insurance plan?
Providing you the care that you need so that you can get back to doing what you want to is important to us! CPT is always willing to assist our patients with the financial burden associated with co-payments, deductibles, and co-insurance costs. If cost of care is a concern, please do not hesitate to mention it to

our front desk administrator or your therapist. All staff are familiar with our policies to help with these circumstances and will initiate the necessary process.

Do I need to complete paperwork?
Yes. Most of the necessary paperwork is attached here. It is important that you complete ALL of it to the best of your ability. If there is something you do not understand, simply leave it blank and we can review it with you during your first visit. If you maintain a separate copy of your medical history and/or medication list, you may present them with this paperwork (in place of writing it out) and we can make a copy for your patient chart.

Should I bring any test results to my appointment?
Very often, patients have undergone tests that are pertinent to their reason for a referral to physical or occupational therapy. These may include tests such as X-ray, EMG, MRI, CT scan, or bloodwork. If you have had testing relevant to your diagnosis, please bring a copy of your test results to your first appointment OR notify your therapist about the testing and where it was performed – we can request a copy of the results from the service provider.

How often will I have appointments?
Your therapist will complete an initial examination on your first visit. At the end of that visit, the therapist will discuss with you their findings and thoughts about appropriate interventions, which includes the frequency and duration of your treatment. Typically, patients are seen 2-3x/week for a period of 4 – 6 weeks. This varies based upon your diagnosis and complexity of your problem(s).

How long are the appointments?
Initial visits are usually a full hour. After that, visits typically last 45 – 75 minutes, depending upon the condition we are seeing you for and how much time your therapist determines is needed to provide the best care for you. No two patients are the same!

Is there anything else I need to know?
We are excited to have you come in to see us! We do our best to create a fun atmosphere that helps you heal and feel supported while doing so. Please know that we are here for YOU! Never hesitate to reach out to any of our staff members with an issue or concern!

We are looking forward to meeting you and getting you started on the road to recovery!

Sincerely,

The CPT Team

Medical history

Patient name:_____ Date of Birth:_____ Age:_____

MR # :_____

Date:_____ Provider:_____ Owner:_____

☐ Medical history was supplied by caregiver/patient and reviewed by clinician

Reason for Therapy

Date condition began:_____

Is this a work related injury? ☐ Yes ☐ No

Date of next doctor appointment for this condition:_____

Please describe the onset and history of the current condition(s): _____

_____

_____

Current Symptoms

Rate your symptom intensity in the past 5 days:

(0 is no pain or symptoms and 10 is worst possible pain or symptoms)

Symptoms at worst:_____out of 10

Symptoms at best:_____out of 10

Surgery

Did you have surgery for this condition? ☐ Yes ☐ No

Date of surgery (if applicable):_____

Type of surgery:_____

How do activities change the symptoms?

Please list activities that make your symtoms worse:_____

_____

_____

Please list activities that make your symptoms better:_____

_____

_____

What activities can you no longer do because of this condition? _____

_____

_____

Diagnostic Tests

List any diagnostic tests you have recieved for this condition:_____

_____

_____

_____

Previous Therapy

Have you Received Therapy Past 12 Months? ☐ Yes ☐ No

If yes, for what condition?_____

_____

_____

Medical Conditions

Do you have any medical conditions that you currently suffer from or have suffered from in the past? ☐ Yes ☐ No

List of Medical Conditions

Check any medical conditions that you have a history of:

☐ Abnormal Bleeding	☐ Chronic Back Pain	☐ Diabetes Type II	☐ High Cholesterol	☐ Osteoarthritis
☐ Angina	☐ Chronic Neck Pain	☐ DVT	☐ HIV/AIDS	☐ Osteoporosis
☐ Anxiety	☐ Closed Head Injury	☐ Fibromyalgia	☐ Hypertension	☐ Psoriatic Arthritis
☐ Arrhythmia	☐ Colitis	☐ Frequent UTI	☐ Hypothyroidism	☐ PVD
☐ Asthma	☐ Congestive Heart Failure	☐ GERD	☐ IBS	☐ Rheumatoid Arthritis
☐ Bipolar Disorder	☐ COPD	☐ Glaucoma	☐ Joint pain	☐ Scoliosis
☐ Blood Clotting Disorder	☐ Crohn's Disease	☐ Gout	☐ Lymphedema	☐ Seizure Disorder
☐ Bowel Incontinence	☐ CVA (Stroke)	☐ Heart Disease	☐ Migraine Headaches	☐ Shortness of Breath
☐ Cancer	☐ Degenerative Disc Disease	☐ Hepatitis B	☐ MRSA	☐ Sleeping Disorder
☐ Carpal Tunnel Syndrome	☐ Depression	☐ Hepatitis C	☐ Multiple Sclerosis	☐ TB
☐ Cellulitis	☐ Diabetes Type I	☐ Hiatal Hernia	☐ MI/Heart Attack	☐ Urinary Incontinence

Other Conditions

Do you have a pacemaker? ☐ Yes ☐ No

List any conditions not already included: _____

_____

Surgeries

Have you had any surgeries? ☐ Yes ☐ No

List surgeries you have had including date if known:

Surgeries and Procedures		
Type	**Date**	**Results/Details**

Medications

Do you take any medications or over the counter supplements? ☐ Yes ☐ No

Please list current medications: (include dose and frequency if possible)

Medications, Vitamins, and Supplements				
Name	**Dose**	**Dose (unit)**	**Frequency**	**Method (oral, injection, etc.)**

Allergies

Do you have any allergies to medications, food, or other substances that we need to be aware of? ☐ Yes ☐ No

Please list current allergies:

Allergies			
Allergen	**Type (Drug/Food allergy, etc.)**	**Severity**	**Onset date**

Who do you live with?

Select all that apply:

☐ Spouse ☐ Child(ren) ☐ Parent(s) ☐ Alone ☐ Other Family Members ☐ Other:_____

Is assistance provided by other who do not live in the home? ☐ Yes ☐ No _____

Type of home

☐ Single Level Home ☐ Ground Floor Apartment ☐ Assisted Living Facility ☐ Other:_____

☐ Two Level Home ☐ Upper Level Apartment ☐ Skilled Nursing Facility _____

Stairs

Are there stairs to get into the home? ☐ Yes ☐ No How many?

Handrail? ☐ Yes ☐ No ☐ Right side only ☐ Left side only ☐ Both sides

Are there stairs inside of the home? ☐ Yes ☐ No How many?

Handrail? ☐ Yes ☐ No ☐ Right side only ☐ Left side only ☐ Both sides

Is there a ramp to get into the home? ☐ Yes ☐ No

Where is the bathroom located? ☐ Main level ☐ Upper level

Where is the bedroom located? ☐ Main level ☐ Upper level

Disability History

Are you permanently disabled? ☐ Yes ☐ No Year of disability:_____

Please describe disabilities:_____

_____

_____

Tobacco Use

Do you smoke cigarettes? ☐ Yes ☐ No

If yes, how many packs per day?_____

Have you smoked in the past? ☐ Yes ☐ No How many years did you smoke for? _____

How many packs per day?_____ How many years ago did you quit smoking? _____

Do you use other tobacco products? ☐ Yes ☐ No

Type: ☐ Smokeless Tobacco ☐ Cigars ☐ Pipe ☐ E-cigarette or Vape

Alcohol Use

Do you drink alcohol? ☐ Yes ☐ No

How many times per week?_____ How many drinks each time?_____

Drug Use

Do you use drugs? ☐ Yes ☐ No

Type: ☐ Cocaine ☐ Heroin ☐ Pain Medications ☐ Other

☐ Ecstasy ☐ Marijuana ☐ Other prescription medications

Additional Information:

_____

_____

_____

Work Status

What is your current work status? ☐ Employed Full Time ☐ Employed Part Time ☐ Full time student ☐ Part time student ☐ Retired ☐ Permanently Disabled ☐ Not employed

What is your occupation?

What is your current ability to work? ☐ Able to perform all duties ☐ No formal restrictions ☐ Restricted duties/schedule ☐ Off work ☐ Temporary Disability

Do you have any restrictions on your job duties currently due to your current conditions? ☐ Yes ☐ No

Please provide details:

Work Duties

Currently able to perform:

	Yes	No	N/A		Yes	No	N/A
Sitting for extended periods	☐	☐	☐	Lifting Heavy Weights	☐	☐	☐
Standing for extended periods	☐	☐	☐	Operating Heavy Equipment	☐	☐	☐
Repetitive Bending	☐	☐	☐	Driving	☐	☐	☐
Repetitive Lifting	☐	☐	☐	Typing/computer operation	☐	☐	☐
Lifting moderate weights	☐	☐	☐	Walking	☐	☐	☐

Equipment

Do you use any equipment to assist with mobility or daily activities? ☐ Yes ☐ No

Please indicate any equipment that you use:

☐ Cane	☐ Power Wheelchair	☐ Dressing Aid	☐ Hoyer Lift	☐ Hand Splint(s)
☐ Walker	☐ Scooter	☐ Special Utensils	☐ Stair Lift	☐ Braces
☐ 2-Wheeled Walker	☐ Slide Board/Transfer Aid	☐ Reacher	☐ Track System	☐ TENS Unit
☐ 4-Wheeled Walker	☐ Raised Toilet Seat	☐ Power Lift Recliner	☐ Stander	☐ Oxygen
☐ Manual Wheelchair	☐ Bath/Shower Chair	☐ Hospital Bed	☐ Axillary Crutches	☐ Loftstrand crutches

☐ Other: _____

Feeding

Do you have any concerns related to feeding? ☐ Yes ☐ No

Current Feeding Adaptations

☐ Thickened Liquids: Consistency: _____

☐ Adapted Utensils Details: _____

☐ Adapted seating Details: _____

☐ Calorie supplements Details: _____

☐ Tube Feeding Amount: _____ Times per day: _____ ☐ Continuous ☐

Please provide some details of these concerns: _____

_____

_____

Memory

Do you have any concerns about your memory? ☐ Yes ☐ No

Please provide some detail about these concerns: _____

_____

_____

_____

COMPREHENSIVE PHYSICAL THERAPY

CONSENT FOR TREATMENT

I, the undersigned, hereby agree and give my consent to COMPREHENSIVE PHYSICAL THERAPY to administer such treatment and care as is prescribed and considered therapeutically necessary on the basis of findings during the course of treatment. I also authorize COMPREHENSIVE PHYSICAL THERAPY to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for the services rendered. The information provided is accurate to the best of my knowledge.

Relationship to Patient:

_____ _____

Signed By Date

Patient Forms and Consents
COMPREHENSIVE PHYSICAL THERAPY

Financial Policy

No Show & Cancellation Fee Policy: In the event you need to cancel your appointment, we require at least 24 hours' notice. Your appointment time is very important to us. If we do not get at least a 24 hours' notice of your cancellation, we may not be able to schedule another patient who may need that time slot. This is detrimental to us and to the patients we serve.

Repeated no shows or late cancellations are disruptive to the optimal delivery of care and may indicate a lack of commitment to your health and wellness. As a result, 3 late cancellations and/or no shows may result in discontinuation of therapy. In the event that you are discharged from our care, your referring provider and/or claims manager will be notified of the reason for discharge from therapy. We realize that emergencies do occur and we will give reasonable consideration for illnesses or unforeseen emergencies.

Financial Policy: A medical insurance policy is a contract between you and your insurance company. Coverage depends upon your insurance company and the specific plan you have chosen. COMPREHENSIVE PHYSICAL THERAPY is contracted with most insurance companies and, as a service to patients, we agree to submit your claims directly to them. You may need a current physician's prescription/referral for therapy services in order to submit your claim. Referrals are current for 30 days unless otherwise specified. In order for us to submit a claim to your insurance company, we will need a copy of your insurance card. Known patient responsibilities (such as copayment) are due at the time of service. Any invoiced billing is due within 30 days of receipt of COMPREHENSIVE PHYSICAL THERAPY statement. A fee of $25.00 will be charged for any check returned by the bank for Non-Sufficient Funds.

All patient co-payments and deductibles are due at time of treatment. Co-payments not paid at the time of each visit will be subject to a $25.00 administrative fee.

Medicare Patients: If you choose to schedule therapy without a physician's prescription/referral, we MUST obtain a signed therapy plan of care from your physician within 30 days of your initial visit. Also, you must be discharged from any home health care services or agency prior to initiating outpatient therapy. Medicare will not pay for both home health and outpatient care simultaneously.

Motor Vehicle Collision - Auto PIP/Third Party: We will bill your Personal Injury Protection Insurance (PIP) as a courtesy to you. If you do not have a direct PIP Claim you can choose to submit your personal health insurance or pay at the time of service at the Cash-Pay rate.

Work Injury Claims: Medical expenses resulting from a workplace injury/disease will be submitted to the workers' compensation program on an open claim. However, if a claim is denied for any reason, the patient will be fully responsible for the total cost of the care provided.

Cash-Pay Policy: We offer patients a discount equal to 10% of our usual and customary charges for services paid in full at the time of service. This discount is based on the administrative savings to our practice when receiving payments up front rather than billing for services. We will not bill your insurance company for services provided under this arrangement. No forms will be produced now or in the future for you to submit claims for insurance billing.

Unaccompanied Minors Policy: COMPREHENSIVE PHYSICAL THERAPY is authorized to provide treatment to a minor as appropriate when they arrive to an appointment unaccompanied by a parent/guardian; this may include changes in the current therapy the minor is receiving including treatments and exercises. The above financial policy is applicable to the guarantor of the unaccompanied minor.

I understand the COMPREHENSIVE PHYSICAL THERAPY and Financial policies as described above. I authorize my medical benefits to be paid directly to COMPREHENSIVE PHYSICAL THERAPY for my services. I acknowledge that I am financially responsible for any balance due on all covered or non-covered services. I authorize the release of any medical or other information necessary to process the claim or provide continuity of care. I consent to receive treatment as prescribed by my provider.

_____ _____

Signed By Date

Patient Forms and Consents
COMPREHENSIVE PHYSICAL THERAPY

NOTICE OF PRIVACY PRACTICES
Effective 01/01/2020, Revised 01/01/2020

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). It describes how we may use or disclose your protected health information, with whom that information may be shared, and the safeguards we have in place to protect it. This notice also describes your rights to access and or refuse the release of specific information outside of our system except when the release is required or authorized by law or regulation.

Acknowledgement of Receipt of this Notice
You will be asked to provide a signed acknowledgment of receipt of this notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care services will in no way be conditioned upon your signed acknowledgment.

Who Will Follow this Notice
All physicians, licensed health care personnel, employees, staff and other office personnel. Any independent health care professional who may provide services at our office and is authorized to enter information into your medical record. All students or trainees. Any persons or companies with whom COMPREHENSIVE PHYSICAL THERAPY contracts for services to help operate our practice and who have access to our patients' medical information.

Our Responsibility Regarding Protected Health Information
Your 'protected health information is individually identifiable health information. This includes demographics such as age, address, email address, and relates to your past, present, or future physical or mental health or condition and related health care services. We are required by law to do the following:

Make sure that your protected health information is kept private.

Give you this notice of our legal duties and privacy practices related to the use and disclosures of your protected health information.

Follow the terms of the notice currently in effect.

Communicate any changes in the notice to you.

We reserve the right to change this notice. Its effective date is at the top of the first page and at the bottom of the last page. We reserve the right to make the revised or changed notice effective for health information we already have about your child as well as any information we receive in the future. You may obtain a Notice of Privacy Practices by calling the phone number at the top of this notice.

Our System
COMPREHENSIVE PHYSICAL THERAPY works with several agencies and referral sources. Your health information will be shared in the following manner:

Treatment

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes disclosure to your physician or other health care providers who become involved in your care.

Within our office for administrative activities, quality assessment, oversight and peer review.

With our billing personnel and as necessary to obtain payment for your health care services.

With your insurance company or other payers as required for payment.

With the referring agency and case manager.

With any other provider, school and/or agency with your written request. You may request written or verbal information sharing in writing. Your request should include a specified period of time for information sharing.

Required by Law
We may use or disclose your protected health information if law or regulation requires the use or disclosure. We will notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

Health Oversight
We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. These health oversight agencies might include government agencies that oversee the health care system, government benefit programs, other government regulatory programs, and civil rights laws.

Legal Proceedings
We may disclose protected health information during any judicial or administrative proceeding, in response to a court order or administrative tribunal (if such a disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request, or other lawful process.

Parental Access
We may disclose your protected information to parents, guardians and persons acting in similar legal status.

For Health Care Operations
COMPREHENSIVE PHYSICAL THERAPY, staff and business associates may use and disclose medical information about you to operate this office. For example, COMPREHENSIVE PHYSICAL THERAPY may use medical information to call out your name in the waiting room, to review treatment and services or to evaluate the qualifications and performance of therapists in caring for you. COMPREHENSIVE PHYSICAL THERAPY may also disclose information to licensing authorities or offices who evaluate qualifications and review care to determine if COMPREHENSIVE PHYSICAL THERAPY and its therapists can be licensed, credentialed, certified or approved under a health plan or to treat patients at a particular facility. COMPREHENSIVE PHYSICAL THERAPY may contract with other professionals or companies, such as medical record transcription services, consultants, financial advisors or legal counsel, to help us run the practice and who have agreed to follow our Notice of Privacy Practices.

Contacting You
Unless COMPREHENSIVE PHYSICAL THERAPY has agreed in writing to your written request to handle these matters differently, COMPREHENSIVE PHYSICAL THERAPY may use and disclose medical information to leave you a message or send you a letter concerning an appointment or to ask you to call concerning your care or your account. COMPREHENSIVE PHYSICAL THERAPY will use the contact information that you provide.

Individuals Involved in Your/ Your Childs Care
COMPREHENSIVE PHYSICAL THERAPY may disclose medical information about you/your child to a friend or family member who is involved in your/ your childs medical care, unless you object. You can object to these disclosures by notifying COMPREHENSIVE PHYSICAL THERAPY in writing that you do not wish any or all individuals involved in your/ your childs care to receive this information. If you are not present or cannot agree or object, COMPREHENSIVE PHYSICAL THERAPY will use our professional judgment to decide whether it is in your/ your childs best interest to disclose relevant information to someone who is involved in your/ your childs care.

Uses and Disclosures of Protected Health Information Requiring Your Permission
In some circumstances, you have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. Please notify our office in writing if you do not want your protected health information to be discussed with those present during the session. If your child receives therapy at our office the therapist may discretely share your progress in the waiting room in front of other patients. If you do not wish to have your progress shared in the waiting room, please notify our office in writing.

Your Rights Regarding Your Health Information
You may exercise the following rights by submitting a written request to the COMPREHENSIVE PHYSICAL THERAPY office.

You may inspect and obtain a copy of your protected health information that we keep as a part of medical and billing records.

You may ask us not to use or disclose any part of your health information for treatment, payment, or health care operations.

Your request must be made in writing. This request will be honored if we mutually agree that the restriction will not harm your child.

You may request that we communicate with you using alternative means or at an alternative location. We will not ask you the reason for your request.

We will accommodate reasonable requests, when possible.

If you believe that the information we have about your child is incorrect or incomplete you may request an amendment to your protected health information as long as we are responsible for and maintain this information.

Federal Privacy Laws
This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). There are several other privacy laws that also apply including the Freedom of Information Act and the Privacy Act. These laws have been taken into consideration in developing our policies and this notice of how we will use and disclose your protected information.

Changes to the Notice of Privacy Practices
COMPREHENSIVE PHYSICAL THERAPY reserves the right to change this notice. COMPREHENSIVE PHYSICAL THERAPY reserves the right to make the revised or changed notice effective for medical information already held about you as well as any information received in the future. COMPREHENSIVE PHYSICAL THERAPY will post a copy of the current notice in the office. The notice will remain in effect for each subsequent visit unless changed. If the notice changes, a copy will be available to you upon request.

Questions and Complaints
If you have any questions about this notice, please contact the Privacy Officer at (570) 785-2018. To notify our office in writing of a request please mail to the following: Privacy Officer, COMPREHENSIVE PHYSICAL THERAPY. 354 Main St, Forest City PA, 18421-1418. If you have a complaint about your privacy rights, you may file a written complaint with this office or with the Secretary of the United States Department of Health and Human Services. To file a complaint with our office, contact our Privacy Officer at (570) 785-2018. You will not be penalized for filing a complaint.

_____ _____

Signed By Date

Patient Forms and Consents
COMPREHENSIVE PHYSICAL THERAPY

PAYMENT FOR SERVICES AGREEMENT

Services to be Provided

COMPREHENSIVE PHYSICAL THERAPY will provide therapy services for you/your child (patient) in accordance with the orders provided by the patient's physician. It is understood that licensed therapists employed by COMPREHENSIVE PHYSICAL THERAPY will complete the services provided. The responsibly party gives permission for the patient to receive therapy services provided by COMPREHENSIVE PHYSICAL THERAPY

Insurance Benefits

COMPREHENSIVE PHYSICAL THERAPY will verify the patient's benefits, file the claims for services provided with the insurance carrier, and notify the responsible party of their financial responsibility. The responsible party understands that the verification of benefits and authorization is not a guarantee of payment and that they are responsible for all charges not paid by the insurance company.

Assignment of Insurance Benefits

The responsible party authorizes any insurance carrier that provides insurance coverage for the patient, to make direct payments to COMPREHENSIVE PHYSICAL THERAPY for any speech pathology services rendered. The responsible party will accurately inform COMPREHENSIVE PHYSICAL THERAPY of the patient's insurance coverage and provide information regarding coverage changes within 5 working days of the change.

Release of Information for Reimbursement

The responsible party authorizes the release of information pertaining to the patient's diagnosis and course of treatment to COMPREHENSIVE PHYSICAL THERAPY by the patient's physician and any other therapy service providers involved in the patient's care. The responsibly party also authorizes the release of information to the patient's physician and any other agencies related to reimbursement issues.

I give permission to COMPREHENSIVE PHYSICAL THERAPY to release information to my insurance company and bill for services on my behalf. I understand that authorization and verification of benefits is not a guarantee of payment and that I am responsible for any charges not covered by insurance.

_____ _____

Signed By Date

Patient Forms and Consents
COMPREHENSIVE PHYSICAL THERAPY

THERAPY SERVICES AGREEMENT

If you need to cancel because of illness or another pressing commitment, please call the front desk staff at the scheduled office where you are seen as soon as possible.

Office - (570) 251-3499

You may also let our scheduling team know in advance about upcoming cancellations. Cancellation records are reviewed for frequency of no-shows and cancellations. We realize life can be very hectic and you often have multiple appointments to maintain. If circumstances are making it difficult for you to attend regularly, we may need to find another appointment time, decrease frequency, or put your child on hold until therapy can be made a higher priority. If a vacation or surgical procedure will cause you/your child to miss more than two weeks in a row, you/they may need to be placed on hold so another client may utilize that time slot.

If you miss your appointment without calling to cancel, it is considered a No Show.
1st/2nd No Show – you will receive a call from our office with an attempt to reschedule the missed appointment.
3rd No Show – you will be discharged from COMPREHENSIVE PHYSICAL THERAPY and your referring physician will be notified.

*Please be aware no show/cancellation reports are monitored and staff are required to enforce these policies.

I agree to the Therapy Services Agreement.

_____ _____

Signed By Date

Patient Forms and Consents
COMPREHENSIVE PHYSICAL THERAPY

STUDENT PARTICIPATION AGREEMENT

COMPREHENSIVE PHYSICAL THERAPY strives to provide quality treatment services for you and/or your child. Part of providing quality treatment is supervising students in direct delivery of physical therapy and occupational services. Their participation during treatment sessions prepare them for the workplace.

We are currently affiliated with multiple colleges and universities for practicum placements. These students are being educated to develop as professionals, including physical therapists, physical therapist assistants, occupational therapists and occupational therapist assistants. We would like your permission to allow the students direct supervised contact during you and/or your child's therapy sessions. All students sign a confidentiality agreement indicating they will keep the information they encounter at COMPREHENSIVE PHYSICAL THERAPY in the strictest of confidence.

Please feel free to ask any questions regarding this policy.

I agree to the student participation agreement.

_____ _____

Signed By Date