



Acknowledgment of Notice of Privacy Practices

____ (Initial) I acknowledge and agree that I have been informed to read the Notice of Privacy Practices Policy on Rocky Mountain Physical Therapy’s website. In addition, I acknowledge I can request a copy of the Notice of Privacy Practices in writing at any time.

Acknowledgment of Surprise Billing Disclosure

____ (Initial) I acknowledge and agree that I have been informed to read the Surprise Billing Disclosure on Rocky Mountain Physical Therapy’s website. In addition, I acknowledge I can request a copy of the Surprise Billing Disclosure in writing at any time.

Cancelation and No-Show Policy

____ (Initial) It is the patient’s responsibility to give Rocky Mountain Physical Therapy at least 24 hours’ notice if they are unable to attend an appointment. All efforts will be made to reschedule a canceled appointment within the same week to stay on the patient’s recommended plan of care. Our time is valuable to our patients and this policy allows us to offer appointments to all patients in a timely and effective manner. If a patient has 3 or more canceled or no-showed appointments, they will be changed to “Day-Of Scheduling” status and not allowed to schedule appointments on future days.

Informed Consent

“Informed Consent” is a process for getting permission before we provide therapeutic services to you, the patient. A sound informed consent includes an explanation of the potential risks, benefits, and alternatives to any treatment that has been proposed to you or, in the case of a minor, your representative. We will discuss the Plan of Care established for you and give you ample time to ask questions about it; your consensus is a critical part of achieving a successful outcome.

Potential Benefits: You may experience improvement in your symptoms and functional activities as well as resolution of other key complaints or problems. In addition to treatment, we provide education to you about your condition throughout your episode of care. This education is often accompanied by handout material that you can refer to regarding proper techniques and home program execution. These resources will help you maintain a sound level of function and will also help you minimize symptoms, should they reoccur.

Potential Risks: You may experience an increase in your current level of pain, if pain is part of your complaints. Many times increased activity or therapy interventions will bring on some discomfort, this is usually temporary. If your pain or discomfort does not subside within twenty-four (24) hours, you should discontinue any home program involving that particular activity, if applicable, and contact your therapist.

Alternatives: We establish a Plan of Care based on the best interventions for your condition, but on occasion our choice of treatment is not well tolerated. You are asked to voice any unfavorable reaction you experience to any aspect of your treatment so that we can modify or terminate it promptly and progress your rehabilitation. If you decide not to continue your participation in your therapy program you will be asked to consult with your physician about other treatment alternatives.

No Warranty: Please note that we cannot make any promises or guarantees regarding a full resolution of and/or correction of your condition. We will, however, work in conjunction with you to achieve optimal improvement.

I have read the above information and I consent to the evaluation(s) and treatment provided by Rocky Mountain Physical Therapy

Name: _____

Signature: _____

Date: _____