



270 COMMERCE DRIVE, SUITE 190, FORT WASHINGTON, PA 19034  
215-654-1520 • FAX 215-654-1529 • WWW.FWREHABANDFITNESS.COM • FWRFC@AOL.COM

### *CONDITIONS & CONSENT FOR PHYSICAL THERAPY*

I understand that I am a patient of Fort Washington Rehabilitation and Fitness Center, and their independent physical therapy practitioners at Fort Washington Rehabilitation and Fitness Center. My care is the exclusive responsibility of the practitioners of Fort Washington Rehabilitation and Fitness Center, as well as any other practitioners who also may practice at this location.

**Cooperation with treatment:** In order for physical therapy treatment to be effective, I must come to scheduled appointments unless there are unusual circumstances. I understand and agree to cooperate with and perform the home physical therapy program intended for me. If I have trouble with any part of my treatment program, I will discuss it with my therapist.

**Cancellation Policy:** I understand that if I cancel more than 24 hours in advance, I will not be charged. I understand that if I cancel less than 24 hours in advance, I will pay a cancellation fee of \$ 25.00. To be paid at the time of your next appointment. Fort Washington Rehabilitation and Fitness Center reserves the right to terminate my treatment if I cancel my appointments with unreasonable frequency and/or without proper notice.

**No warranty:** I understand that there are no guarantees regarding a cure for or improvement in my condition. I understand that my physical therapist will outline and discuss goals of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

**Informed consent for treatment:** The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to me. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition.

**Potential risks:** I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury or condition. This discomfort is usually temporary; if it does not subside in a reasonable time period, I agree to contact my physical therapist.

Patient's Initials \_\_\_\_\_ (page 1)

**Potential benefits:** I may experience an improvement in my symptoms and an increase in my ability to perform daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

**Alternatives:** If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physical therapist, as well as my physician or primary care provider.

**Release of medical records:**

I authorize the release of my medical records to the following physicians/primary care provider, lawyer/law office, or insurance company:

---

---

---

**Financial and insurance responsibilities:**

I agree to pay for my treatments at time of service by cash, check, or MasterCard/Visa/Discover unless other mutually agreed upon arrangements have been made. I understand it is my responsibility to call my insurance company ahead of time, and obtain any pre-authorization that is necessary, and get an estimate of my benefits. I understand that by request, Fort Washington Rehabilitation and Fitness Center will provide me with a receipt on the same day of service, which is my responsibility to submit to my insurance company.

**I have read the above information and I consent to physical therapy evaluation and treatment.**

---

Patient Name (Print)

---

Date

---

Patient or Parent/Guardian Signature

---

Physical Therapist Signature