Patient Agreement Form

Thank you for selecting Combat Athletes Physical Therapy (hereinafter CAPT). In order to facilitate your treatment, we ask you to read and sign this agreement and authorization

Consent for Treatment

I have a condition requiring physical therapy intervention and consent to the delivery of such care. In order to improve my physical condition in regards to pain, range of motion, strength, or another type of physical impairment, I consent to enter CAPT program for evaluation and treatment.

I request and authorize the licensed staff of CAPT to render treatment, and to perform appropriate procedures that my referring provider may deem reasonable and necessary for my diagnosis. I understand that my physical therapy care and treatment may be provided by a physical therapist or physical therapy assistant. I am aware that there are certain risks involved with a physical therapy program.

Every effort is made to minimize my risk by continuous assessment of my condition throughout my therapy. 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.
_____ (initials).

Privacy Notice Acknowledgement

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I hereby acknowledge that I have had the opportunity to review a copy of CAPT's "Notice of Privacy Practices." I understand that I am responsible for reading this Notice and notify CAPT, in writing, of any request for restrictions in the use or disclosure of my individually identifiable health information. CAPT has the right to revise this Notice at any time and will post a copy of the current Notice in the office in a visible location at all times. I am aware that CAPT has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information it maintains. CAPT will provide me with a copy of its most recent Notice upon my request.
_____ (initials).

Payment

Payment is due on each day services are rendered. We accept credit card, online payment, cash, money order, or check. There is a $25.00 charge for all returned checks. When an account has received two returned checks, it will automatically be placed on a "cash" only status. You agree to be responsible for payments of all fees in full at the time of your appointment.
_____(initials).

Media Release

I grant permission and have the right to grant permission to CAPT to use the photo and/or video provided by me or taken with my permission. I understand that this consent is perpetual, that it may not be revoked, and that it is binding on my heirs and assigns. I grant CAPT to use, reproduce, edit, exhibit, project, display, copyright, and/or publish photographic pictures, moving pictures, and/or videotaped images that I took and to circulate the same in all forms and media (including, but not limited to social media (twitter, Facebook, Instagram, etc.), Youtube, and any publications, advertising/promotion, videotapes, audiotapes, compact disc, computer files and photographs) for educational, trade, all forms of advertising/promotions or any lawful purpose. I wave all claims to compensation and damages. I acknowledge and agree that I have complied with all state and federal laws regarding privacy, including the Health Insurance Portability and Accountability Act (HIPPA) Standards for Privacy of Individually identifiable health information (privacy Standards) and have obtained any necessary authorization and consent.

_____ (initials)

Appointments/Cancellations

We typically see patients by appointment. Please call ahead if you think you will be late. We appreciate 24 hours notification of cancellations. You may leave a message on voicemail if you are calling after hours. If there are consistent lapses in scheduled attendance, you will incur a $50 fee for each visit missed, that will be assessed to your account.

_____(initials).

Adult Supervision

Those under the age of 16 receiving treatment at our facility must be accompanied by a parent or legal guardian during each physical therapy appointment.

_____(initials).

Other Information

I understand I may also be charged for therapy products, educational materials, and other administrative expenses, including copies of medical records.

_____(initials).

I hereby authorize and request CAPT to provide such medical care and administer procedures and treatment as in the judgment of the California State licensed physical therapist in attendance and deemed necessary and advisable. The patient certifies that all information provided to this office is true and correct, to the best of their knowledge. **The patient grants their consent to this office and its staff to render treatment as deemed necessary by the attending physician.** If the patient is a minor child, under the age of eighteen (18) at the time of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment as a provider for herein. The patient may refuse treatment at any time.

By signing this agreement, I acknowledge that I have read, understand, and agree to the above terms and conditions.

Patient Signature;_____

Date:_____

Witness Signature:_____

Date:_____