Consent to Treat, Financial Agreement & Media Release

Patient Name: ________________________________

Date of Birth: ___________ **Date:** _____________

1. Consent to Evaluation and Treatment

I ___________________(PRINT NAME) voluntarily consent to receive physical therapy evaluation and treatment services from licensed professionals at PT Kinetics, for my prescribed conditions. The specific plan of care will be determined based on my clinical presentation and may change over time.

2. Understanding of Cash-Based Services

I acknowledge and understand the following:

- This is a cash-based practice. This means I ______(initial) am responsible for payment at the time of service, regardless of whether I have health insurance coverage.
- PT Kinetics does not bill insurance companies on my behalf.
- I may request a Superbill to submit to my insurance provider for possible out-of-network reimbursement, but reimbursement is not guaranteed.
- It is solely my responsibility to understand my insurance policy and determine if services are eligible for reimbursement.

3. Financial Responsibility

I ______(initial) agree to the following:

- I am financially responsible for all charges incurred during my care.
- Payment is due in full at the time of each visit, unless prior arrangements have been made.
- I understand the PT Kinetics fee schedule and have been informed of all applicable charges.
- Missed appointments or cancellations with less than 24 hours' notice may result in a fee, per the clinic's cancellation policy.

4. Risks and No Guarantees

I ______(initial) understand that, as with any form of treatment, there are potential risks, including temporary pain, discomfort, or aggravation of symptoms. I acknowledge that results are not guaranteed, and treatment outcomes may vary based on individual response.

5. Right to Decline o r Withdraw Consent

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I understand that I _______(initial) have the right to decline any specific treatment or withdraw my consent at any time. I also understand that doing so may affect the effectiveness or continuity of my care.

6. HIPAA and Communication

I __________ (initial) authorize PT Kinetics to communicate with me regarding my care, appointments, and administrative matters via phone, email, or text, in accordance with HIPAA privacy rules. I understand that electronic communication carries some risk to confidentiality, though the clinic will take reasonable precautions.

7. Acknowledgment of Understanding

By signing below, I ________(initial) acknowledge that:

- I have read and fully understand this form.
- I have had the opportunity to ask questions and receive answers.
- I consent to receive physical therapy services as described above.
- I accept full financial responsibility for all services rendered by PT Kinetics .

8. Consent for Use of Photographs and Videos (Media Release)

I _______(initial) give my permission for PT Kinetics to photograph or record video/audio of me for use in the following contexts:

- Social media posts
- Website content and online testimonials
- Marketing and promotional materials
- Educational or training materials

I understand that:

- These images or recordings may be used for educational or commercial purposes at the discretion of PT Kinetics.
- I will not receive financial compensation for their use.
- No personal health information (PHI) will be shared without additional written consent.
- I may revoke this consent at any time in writing, but it will not apply to materials already created or published.

☐ Yes, I consent to the use of my images/videos for media and marketing purposes.
☐ No, I do not consent.

9. Consent to Treat Minors

If the patient is under 18 years of age, the following section must be completed by a parent or legal guardian.

9.1 General Consent to Treat a Minor

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I am the parent or legal guardian of the above-named minor and hereby authorize PT Kinetics to perform physical therapy evaluations and treatments on my child. I understand the risks and benefits of treatment have been or will be explained, and I consent to care being provided under the professional judgment of a licensed physical therapist.

9.2 Consent to Treat Minor Without Parent/Guardian Present

☐ Yes, I give permission for my child to attend physical therapy sessions without a parent or guardian present.

☐ No, my child may only be treated when a parent or guardian is present.

Signatures

Parent (or Legal Guardian) Signature: ___________________________

Printed Name: ___________________________**Date:** _______________

Relationship to Patient (if applicable): ___________________________

Clinician/Witness Signature: ___________________________**Date:** _______________

10. Cancellation & Attendance Policy

By signing below, I ________(initial) acknowledge that:

10.1 Cancellations

- Please cancel/reschedule at least 24 hours in advance when possible.
- 1st late cancellation/no-show (<24 hrs): *No charge*
- 2nd & 3rd instances: *$30 fee each*

10.2. No-Shows & Repeated Cancellations

- After 3 total no-shows or late cancellations → *Same-day scheduling only*, based on availability
- Continued issues may result in discharge from care

3. Late Arrivals

- 10+ minutes late may require rescheduling
- 3 or more late arrivals: *$20 fee*

Patient Signature: _______________________________________**Date:** _______________