DARA WELLNESS & PHYSIO

Consent to Treat

I hereby consent to the evaluation and treatment of my condition by a licensed physical therapist employed by Dara Wellness and Physio. The physical therapist will explain the nature and purposes of these procedures, evaluation, goals, and course of treatment. The physical therapist will inform me of the expected benefits, potential risks, and possible side effects/discomforts that may arise. In addition, the physical therapist will inform me of any possible alternatives to the proposed treatment and the risk and consequences of no treatment.

_____ I give permission for Dara Physical Therapy to provide evaluation and treatment.

_____ I understand that I have the right to refuse any treatment.

_____ I understand that I have the right to ask questions about:

- all aspects of examination and treatment, my condition, diagnosis or prognosis
- the nature or goals and potential benefits of any proposed care
- the inherent risks, complications, or side effects of treatment
- the likelihood of improvement or success following intervention
- reasonable, available alternatives to the suggested care and character of treatment

_____ If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

_____ 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, but if it does not subside in 24 hours, I agree to contact my therapist.

Fee For Service Practice

_____ I have reviewed the clinic fees and understand that I am responsible for payment at the time of service.

_____ I understand it is my responsibility to call my insurance company ahead of time, obtain any pre-authorization that is necessary, and get an estimate of my benefits.

_____ I understand that upon written request my therapist will provide me with a receipt (Superbill) that is my responsibility to submit to my insurance company if desired.

_____ I understand that I will not be able to submit for reimbursement by Medicare.

Printed name: _____

Signed name: _____

Date: _____