Foothills Physical Therapy

Boise: 1673 W. Shoreline Drive, Suite 230, 83702
(208) 343-4700, Fax: (208) 343-4706
Meridian: 1618 S. Millennium Way, Suite 210, 83642
(208) 884-4647, Fax: (208) 884-8984
Eagle: 645 E. State Street, Suite 101, 83616
(208) 939-9594, Fax: (208) 939-9828
foothillspt.com

OUTPATIENT SERVICES CONSENT FOR TREATMENT

Please read carefully

- __________ **Consent for Treatment**: I authorize the staff at Foothills Physical Therapy to undertake such treatment and procedures as deemed appropriate to improve my condition. It is recognized that the practice of medicine is not an exact science and, as such, no guarantees are made by the staff of Foothills Physical Therapy as to the results of treatment or interventions performed. I am advised that I have the full right to a full explanation of any treatment or procedure utilized. I understand that I have the right to refuse treatment; but, in doing so, I also understand that the desired outcome of my treatment program may by affected. Persistent refusal to participate or cooperate in the recommended treatment program may result in my discharge from the program.

- __________ **Personal Property**: It is understood that Foothills Physical Therapy shall not be liable for loss or damage to any personal items brought to Foothills Physical Therapy during your course of treatment.

- __________ **Release of Information**: Foothills Physical Therapy may disclose all or any part of my records to any party or organization responsible for all or part of my therapy charges. Foothills Physical Therapy may disclose all or part of my record to other health care providers including but not limited to, hospitals and physicians. I further agree that Foothills Physical Therapy may release all or any part of my record to any federal, state, or local government body when, in the opinion of Foothills Physical Therapy such bodies may be liable for all or part of my charges in relation to my care and treatment pursuant to statute or rule.

- __________ **Financial Consent**: I agree to be responsible for payment of all outpatient physical therapy charges which are not covered by insurance, and when appropriate, to submit applications to federal, state, and county programs. I understand Foothills Physical Therapy will bill me, my family, and/or other responsible parties for services provided.

- __________ **Assignment of Insurance Billing**: I and/or the responsible party voluntarily assign Foothills Physical Therapy and its independent contracting providers the right to pursue their respective claims for reimbursement from any insurance policy or policies providing coverage for services provided.

- __________ **Notice of Privacy Practices**: I hereby acknowledge that I have received a copy of Foothills Physical Therapy's Notice of Privacy Practices on this day.

(Complete on back)

CANCELLATION & NO SHOW POLICY: Foothills Physical Therapy is founded upon, one-on-one, quality care. We are dedicated to providing an empowering environment with individualized care to achieve optimal healing and functional recovery for our patients. In keeping with our mission we ask that our patient be adherent to their scheduled physical therapy appointments.

- __________ If you should have to cancel an appointment, we kindly request **at least 24 business hours notice.** For patients who do not provide **at least 24 business hours advance notice**, if we feel it is necessary we will charge you a **$35 fee**.

- __________ Repeated cancellations and/or not showing up to appointments **do not** align with the Foothills Physical Therapy mission. Please be advised if you cancel **and/or** no show for **3** physical therapy appointments your therapist may discharge you from care and send your referring provider a note regarding your non-adherence to your therapy plan of care.

Signed ____ Date ___________________

(patient/representative)

Witness ________________________

If you have any questions please ask the front desk. Thank you, Foothills Physical Therapy.