TAMARACK
PHYSICAL THERAPY

Policy Information

It is our intention to provide you with the best care possible. The following information will acquaint you with the procedures and what to expect while you are in physical therapy.

Appointment Information: For each appointment, we set aside 55 minutes of individualized care. This time will include assessment as well as a discussion of your history, goals, progress and future planning.

Cancellation and Lateness Policies: Your appointment time is reserved exclusively for you. If you are unable to keep your scheduled appointment, please call at least 24 hours in advance. Our voicemail is available 24 hours a day. If you have more than one late cancellation or no-show, we reserve the right to cancel all remaining scheduled appointments. If you arrive late, we will work through to the end of your scheduled session. If the therapist is late, you will receive the full amount of time for which you are scheduled.

Billing: We will bill your insurance. It is your responsibility to obtain coverage information from your insurance company prior to your first visit. Co-pays and cash pay are due at the time of service.

Client Acknowledgement and Informed Consent for Physical Therapy Services: Health care rehabilitation is a mutual endeavor. We cannot guarantee the results obtained but we will put forth my best efforts on your behalf. Your full cooperation will enhance the rehabilitation process.

I, _____, request and consent to the physical therapy services and physical therapy procedures. I understand that I am free to withdraw my consent and that I may stop treatment or and procedure at any time. I understand the expected benefits, possible risk, side effects, complications, and discomforts of my rehabilitation. I understand that if I have questions about this information, I should ask. I hereby release Corey Williams, PT or Erin Krekling, PT from any and all liability that may occur in connection with the above-mentioned procedures, except for the failure to perform the procedures with the appropriate medical care. I understand that my signature on this form indicates that I have read and understand the preceding information regarding my treatment. I understand the contents of this agreement and agree to abide by these policies.

Patient's Name (please print): _____ Date: _____

Patient's Signature: _____