Bluegrass Doctors of Physical Therapy, PLLC
The CranioFacial and TMJ Institute

Patient Agreement

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 commence an in-home and or office Bluegrass Doctors of Physical Therapy, PLLC ("Bluegrass PT") program for evaluation and treatment. I request and authorize the licensed staff of Bluegrass PT to render treatment and to perform appropriate procedures that my provider may deem reasonable and necessary for my diagnosis. I understand that my physical therapy care and treatment will be provided by a doctor of physical therapy. I am aware that there are certain risks involved with a physical therapy program. These risks include but are not limited to; exacerbation of current condition, organ puncture, dermal and sub-dermal burns, pneumothorax, hematoma, fractures, joint damage, stroke or even death in the most rarest of cases. Every effort is made to minimize my risk by continuous assessment of my condition throughout my therapy. I will inform my doctor of physical therapy of any changes in my medical condition, or medications, as they may necessitate change in my therapy program. _____ (initials)

I will stop any procedure or activity and inform my therapist of any symptoms of pain, fatigue, shortness of breath, rapid heart rate, dizziness or nausea that may develop during my treatment. _____(initials).

Privacy Notice Acknowledgement: I understand that Bluegrass Doctors of Physical Therapy, PLLC will maintain my privacy to the highest standards and may use or disclose my health information for the sole purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment and/or payment**.**_____(initials).

Appointments/Cancellations: Bluegrass PT requires 24 hours notification of cancellations. In the event I cancel a regularly scheduled appointment with less than 24 hours notice or I am not present or available for a scheduled appointment I will incur a full session fee. If there are 3 consecutive lapses in scheduled attendance I may be removed from the therapist's schedule & will have terminated this agreement. _____(initials).

Insurance: I understand that Bluegrass PT is a fee for service physical therapy provider and Bluegrass PT will not bill my insurance company directly. Further, I understand that I am responsible for asking for an itemized receipt from Bluegrass PT which I may provide to my insurance company, if I have insurance. I understand that I am considered a self pay patient and I am financially responsible for the total amount of the services pro-

vided. Bluegrass PT does not verify insurance coverage prior to providing services and does not guarantee reimbursement for services from my insurance company. _____(initials).

Attire: For access to particular body parts being treated, loose fitting clothing is recommended. If your evaluation includes a diagnosis that involves an assessment of the lumbar spine and or pelvis, this may require you to change clothing and wear a gown. _____(initials).

Adult Supervision: Those under the age of 17 receiving treatment by Bluegrass PT 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 for other administrative expenses, including copies of medical records, & that I will be notified of these charges at the time of service _____(initials).

PATIENT'S SIGNATURE

This agreement must be signed by the Bluegrass PT patient/client unless the patient/client is a minor, incompetent, or physically incapable of signing.

I have read and fully understand the content of this two-page Patient Agreement and hereby agree to and authorize the foregoing provisions.

As used in this document, the terms "I', "me" and "my" refer to and include, in addition to the undersigned, the patient/client named above and others for whom the undersigned is responsible or for whom the undersigned has assumed responsibility in engaging Bluegrass Doctors of Physical Therapy, PLLC to provide services to the patient/client.

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

Patient Signature:_____

Date:_____