foundational concepts

CONDITIONS & CONSENT FOR TREATMENT

I understand that I am a patient of Foundational Concepts, Pelvic Wellness Center, independent healthcare practitioners. My care is the exclusive responsibility of my treating therapist, not of any other practitioners who also may practice at this location.

Cooperation with treatment:
In order for physical/occupational therapy treatment to be effective, I must come to scheduled appointments unless there are unusual circumstances. I understand and agree to cooperate with and perform the home therapy program intended for me. If I have trouble with any part of my treatment program, I will discuss it with my therapist.

Cancellation Policy
I understand that if I cancel more than 24 hours in advance, I will not be charged. I understand that if I cancel less than 24 hours in advance, I will pay a cancellation fee of $75. If I do not show for my appointment and do not call to cancel I will pay the full fee of $125.00 for my treatment session.

No warranty: I understand that there are no guarantees regarding a cure for or improvement in my condition. I understand that my physical/occupational therapist will outline and discuss goals of therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

Informed consent for treatment:
The term "informed consent" means that the potential risks, benefits, and alternatives of physical/occupational therapy treatment have been explained to you. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition.

Potential risks: 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; if it does not subside in 24 hours, I agree to contact my physical/occupational therapist.

Potential benefits: May include an improvement in my symptoms and an increase in my ability to perform daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

Alternatives: 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.

Release of medical records:
I authorize the release of my medical records to the following physicians/primary care provider or insurance company:

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4700 Belleview Ave, Ste 415 Kansas City, MO 64112 Phone (816) 569-2802 Fax (816) 569-5436

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Financial and insurance responsibilities:
I agree to pay for my treatments at time of service, by cash, check, or charge card unless other mutually agreed upon arrangements have been made. I understand it is my responsibility to call my insurance company ahead of time, and obtain any pre-authorization that is necessary, and get an estimate of my benefits. I understand my therapist will submit my claim to my insurance company. I understand that if my evaluation is scheduled on or after May 1, 2018, $25 of the fees collected at my evaluation are facility fees and are not billable to insurance, therefore not qualified for reimbursement or application to my deductible.

I have read the above information and I consent to physical/occupational therapy evaluation and treatment.

_____ _____

Print Name Date

_____ _____

Patient or Guardian Signature Date

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