



Name: _____

PATIENT AGREEMENT

PERMISSION FOR EVALUATION AND TREATMENT: I hereby give permission to the professional staff of the RehabGYM to perform any test(s) and give any treatment(s), deemed appropriate by the professional(s) responsible for my care.

TEAM APPROACH: The RehabGYM integrates the professions of Physical Therapy and Athletic Training in physical rehabilitation, injury prevention and general wellness. I understand that I may be treated by more than one of the RehabGYM's healthcare personnel over the course of care at the discretion of the Professional performing the initial evaluation. I understand that there is a high level of communication between the providers of my care, verbal and written, in providing the optimum attention. If I feel most comfortable with one provider, I have the freedom to request an individual provider as my choice. Your physical therapy initial evaluation will be provided by a *Physical Therapist* who is licensed in the state of Vermont to provide care to a broad range of patients and diagnoses. Subsequent treatments may be provided by a Physical Therapist, an *Athletic Trainer* who is a Vermont licensed health care provider educated to treat physically active individuals with a focus on musculoskeletal care, or a *Physical Therapist Assistant* who is a Vermont licensed professional providing care for a broad range of patients and diagnoses. All Physical Therapy at the RehabGYM is supervised and reviewed by the evaluating Physical Therapist.

RELEASE OF INFORMATION: I hereby authorize the RehabGYM to release any information necessary in coordination of my care to my insurance company(s), my attending physician(s) and/or case manager(s).

PERSONAL PROPERTY STATEMENT: I hereby release the RehabGYM of any responsibility for the loss or theft of any personal items left in any section of the RehabGYM. It is understood that any item may be placed in the hands of a person at reception desk of the RehabGYM for safe keeping.

PAYMENT AGREEMENT: I permit the RehabGYM to bill my insurance carrier directly and request any payments for service to be made directly to the RehabGYM. I certify the insurance identification information given by me is correct. I understand that I am responsible for and agree to pay **all** applicable copays, deductible amounts and charges not covered by my insurance at the time of treatment. If my obligations cannot be paid at the time of treatment, I agree to a payment schedule.

USE AND DISCLOSURE OF HEALTH INFORMATION: I have been shown and offered a copy of the RehabGYM **Uses and Disclosure of Information Statement**. I understand and accept the RehabGYM HIPPA compliant policy and know that I can contact Sharon Gutwin (owner) with any concerns or complaints.

NO SHOW/CANCEL POLICY: Attendance is important to both the outcome of your rehab and success of the RehabGYM business! **PLEASE** cancel appointments at least 24 hrs in advance. You are allowed **ONE** oversight and after that **you will be charged \$20 for cancels under 24 hrs and no shows.**

I understand all statements made above and agree to its terms.

Patient (or guardian if patient is under 18)

Witness

Date