bodies in motion
THE REHAB GYM
stay in motion

NAME:	
DATE OF BIRTH:	
SOCIAL SECURITY #:	

New 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 healthcare provider 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 that individual for my care. My 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 or an *Athletic Trainer* who is a Vermont licensed health care provider educated to treat physically active individuals with a focus on musculoskeletal care. Subsequent treatments may be provided by 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 provided by a *Physical Therapy Assistant* is supervised and reviewed by the evaluating *Physical Therapist*.

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.

Potential Benefits, Risks, and Alternatives: I may experience an improvement in my symptoms, such as decreased pain and discomfort, and an increase in my ability to perform daily activities as well as increased strength, awareness, flexibility and endurance in my movements. I understand that I may temporarily experience an increase in my current level of pain or discomfort, and that if it is not temporary or subsides, I agree to contact the RehabGYM health care personnel providing my treatment. I understand that I should gain a greater knowledge of managing my condition and the resources available to me.

Informed Consent: The potential benefits, risks, and alternative treatment options for my condition and the wide range of services the RehabGYM offers have been explained to me.

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.

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 hours in advance. ***Patient Initials***
I understand that I will be charged $20 for cancellations made with less than 24 hours notice and no-shows. _____

❒ Check here if you would like to receive a **reminder call** for appointments
❒ Check here if you would like to receive our monthly **e-newsletter** (email address: _____)
❒ Check here if you would like to receive your bill **electronically** (email address: _____)

Emergency Contact Name: _____ **Phone:** _____

_____ _____ _____
Patient (or guardian if patient is under 18) *Witness* *Date*