

INTEGRATED PHYSICAL THERAPY OF LITTLETON
PATIENT AGREEMENT

Patient name (please print) _____

I certify that the information provided herein is true and correct. I do not hold Integrated Physical Therapy and/ or its affiliates responsible for any incorrect or omitted information, or for any changes in my future coverage. I also agree that I am responsible for the contract between myself and the insurance company.

CANCELLATION POLICY

We require 24 hours notice when canceling or rescheduling appointments. This allows us to see patients in a timely fashion and provide appropriate treatment as directed by your doctor.

I understand that if I do not give 24 hours notice, I will be charged a fee of \$25.00 for the missed visit that I will pay prior to my next appointment.

Initials _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have reviewed a copy of Integrated Physical Therapy's Notice of Privacy Practices (HIPAA) A copy of this notice is available upon my request.

Initials _____

CONSENT TO TREAT

I understand that I have been referred for rehabilitation treatment and care to Integrated Physical Therapy. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including any risks or alternatives to the treatment plan that was prescribed by my physician and/or recommended by my therapist. By signing this agreement, I consent to have Integrated Physical Therapy provide treatment and care as prescribed by my physician and/or recommended by my therapist.

Initials _____

By signing this form, I agree to all policies listed on this page.

Signature: _____