Renew Manual
PHYSICAL THERAPY

CLIENT INFORMATION:

Name: _____ DOB: _____

Parent/Guardian if Minor: _____

Relationship: _____

Address:_____

Phone: Cell: _____ Home: _____

Email: _____

Preferred contact method: ☐ cell: text / call ☐ home ☐ email

Occupation: _____ Employer: _____

Emergency Contact: _____ Relationship: _____

Phone: _____

How you heard about Renew Manual PT, PLLC:

☐ physician: _____ ☐ friend: _____ ☐ online: _____

☐ other: _____

Name: _____ Phone:_____

FINANCIAL POLICY:

INITIAL EACH

_____ RENEW MANUAL PHYSICAL THERAPY, PLLC (RMPT) requires that all payment be paid at the time of service. By signing this agreement, I understand that RMPT will not be billing my insurance and I understand that I am entering into care as a cash-pay client. If I, as the patient, choose to submit claims to my insurance myself, I understand that my benefits for Physical Therapy services received at RMPT are out-of-network and reimbursement is not guaranteed by my insurance provider and is according to their discretion.

_____ I agree to pay RMPT for all treatments at time of service, by cash or check unless other mutually agreed upon arrangements have been made. A fee of $25 is charged on all returned checks.

_____ Failure to provide 24-hour notice of cancellation or not showing for a scheduled appointment will result in a cancellation fee. 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 or No Show, **I will pay a fee of $75.**

_____ **PRIVACY POLICY:** Acknowledgement of receipt and understanding of privacy notice. I consent to the use and disclosure of protected health information about me for treatment, payment and health care operations. I acknowledge that I have the right to receive a complete detailed copy of the NOTICE OF PRIVACY PRACTICES upon request. RMPT has the right to change its Notice of Privacy Practices from time to time and that I may contact RMPT at any time to obtain a current copy

AUTHORIZATION OF RELEASE: I authorize the following individual(s) to have access to my personal health information.

Name: _____ Relationship: _____

Phone: _____

Name: _____ Relationship: _____

Phone: _____

CONDITIONS / CONSENT FOR TREATMENT

I understand that in order for physical therapy treatment to be most effective, I must commit to the discussed plan of care and perform the home program created for my benefit. If I have any concerns with any part of my treatment program, I will discuss treatment options with my therapist before I consent to treatment.

I have been made aware of the possible benefits, effects, and possible risk or complications associated with my care. I agree to accept the treatment prescribed to me and recognize that I am free to seek other opinions relating to my health.

I waive Renew Physical Therapy, PLLC and Breann Fox, PT, DPT, of any and all liability related to the administration of this unique hands-on treatment. By signing this document, I agree to the conditions stated in this form:

Client/Guardian signature: _____ Date: _____

Print client name: _____

CONSENT FOR TREATMENT OF MANUAL AND VISCERAL THERAPY:

The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to you. I hereby voluntarily consent to physical therapy treatment.

Potential benefits: May include an improvement in your symptoms and an increase in your ability to perform daily activities. You may experience increased strength, awareness, flexibility and endurance in your movements. You may experience decreased pain and discomfort, improved energy mobility, and/or gastrointestinal function. You will have greater knowledge about managing your condition and the resources available to you.

Potential risks: You may experience an increase in your current level of pain or discomfort or an aggravation of your existing injury or condition. You may experience tenderness, bruising, warmth, redness, aching, increased or decreased gastrointestinal motility, or other mild symptoms in the general vicinity of the tissues treated. This discomfort is usually temporary; if it does not subside in 24-48 hours, I agree to contact my physical therapist.

I, the patient, understand in order to best treat my condition that EXTERNAL manual therapy techniques may be performed in the anterior chest region near breast tissue, the anterior pelvic region near genital tissue and structures, and in the posterior and inferior gluteal region near rectum and pelvic bones including the sacrum, coccyx, and ischial tuberosities. My treatment may also include INTERNAL manual therapy techniques in which the therapist will enter my vagina or rectum, with a gloved digit, in order to best treat my condition.
At any time, if I am uncomfortable with any treatment, I will immediately tell my therapist. I understand that I can decline any portion of the evaluation or treatment at any time.

_____ I grant RMPT therapists permission to use of all techniques they have been trained in, including but not limited to soft tissue mobilization, strain-counterstrain, myofascial release, visceral mobilization, joint mobilization, pelvic floor muscle treatment, manual lymph drainage, proprioceptive neuromuscular facilitation techniques, therapeutic exercises, neuromuscular re-education techniques and any other techniques believed to benefit me until I am discharged from care.

Client/Guardian signature: _____ Date: _____

Print client name: _____

I have read and fully understand the statements made on this form and agree that they apply to all treatments I receive from Renew Physical Therapy, PLLC and Breann Fox, PT, DPT. I know I am responsible for all services received and I agree to pay for any and all services rendered at the time of service unless previous arrangements have been made.

Client/Guardian signature: _____ Date: _____

Print client name: _____