KIHEI PHYSICAL THERAPY
KPT Corporation

Consent to treatment at Kihei Physical Therapy:

I wish to receive physical therapy treatment(s) with Kihei Physical Therapy. Accordingly, I authorize and give full consent for services rendered to me under the general and specific instruction of my attending therapist as may be determined by her professional judgment. I understand that I will receive information at the initial visit concerning treatment and options available for my condition. Treatment may consist of, but is not limited to: hot/cold packs, manual therapy, therapeutic exercises, ultrasound, electrical stimulation and other modalities/techniques that the therapist may deem beneficial to recovery. As with any medical treatment side effects may occur. Soreness of muscle/joint, muscle spasm as well as bruising might occur and is usually resolved with the first 24 hours. Care should be taken when driving immediately after treatment.

By signing at the bottom of the page I indicate that I am aware of and accept the conditions as well as the risks of my treatment. I have the right to decline any part of the treatment at any time and in doing so, I am aware that the effectiveness of the treatment may decrease.

All physical therapy treatment options available to my conditions, potential risks, benefits, and alternatives to physical therapy have been explained to me. I have asked any questions and they have been answered to my satisfaction. I understand the risks and benefits and alternatives to treatment. I hereby authorize my physical therapist(s) to examine and treat my condition as she deems appropriate through the use of Physical Therapy and I give authority for these procedures to be performed.

Financial Agreement and Payment Policy

I understand that I am financially responsible for all charges whether or not paid by said insurance. These include deductible, co-payment, cost-share, and/or non-covered benefits. We accept credit cards, cash, or personal checks. Furthermore, I authorize payment of medical benefits to which I am entitled, to Kihei Physical Therapy for medical services rendered. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within 30 days of the receipt of your bill. KPT reserves the right to collect past due balances at the time of service when treating beyond 30 days of your last statement date. Balances over 90 days will be forwarded to a collection agency.

Cancellation Policy

24 hours notice is required for cancellation of patient appointments. We will bill your account **$50.00** for any no-show or cancellation without notice. This fee is not covered by your insurance.

Receipt of Privacy Policy

The practice's Notice of Privacy Practices (HIPPA) is provided and written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. I understand that this practice reserves the right to change terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at or controlled by this practice. I understand I can obtain this practice's current Notice of Privacy on request.

I understand and agree to comply with the terms of KPT's Policy Disclosure and Consent to Treatment

Signature:_____ Date:_____

Printed Name:_____ Relation to patient:_____

if patient is a minor, parent or guardian's signature is required on signature line