

**CONDITIONS AND CONSENT FOR TREATMENT  
REBALANCE PHYSICAL THERAPY**

I understand that I am a patient of Rebalance Physical Therapy, a practice at 234 Woodbine Avenue, 2<sup>nd</sup> Floor, Narberth, PA 19072. My care is exclusively the responsibility of Hina Sheth MS, PT, OCS, MTC not of any other practitioners who also may practice at this location.

**Cooperation with treatment:**

In order for the manual physical therapy treatment to be effective, I will come to the scheduled appointments and perform the individually designed therapeutic exercise program to the best of my ability.

**Cancellation Policy**

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 do not show up for the scheduled appointment, I will pay a cancellation fee of \$35.00. In the event that I cancel less than 24 hours notice of or do not show up a second time, I will be charged the **full session fee**.

No warranty: I understand that there are no guarantees regarding complete improvement in my condition.

**Informed consent for treatment:**

I understand that I will receive information at the initial visit concerning manual treatment care, and other lifestyle changes that may improve my condition.

**Potential risks:** I may experience a temporary increase in my current level of pain or discomfort after initial treatment.

**Potential benefits:** I may experience an improvement in my symptoms and an increase in my ability to perform daily activities; I may experience increased strength, awareness flexibility and endurance in my movements. I may experience decreased pain and discomfort. I will gain a greater knowledge about my condition and the resources available to me to manage it.

**Release of Medical Records:**

I authorize the release of my medical records to the following physicians/primary care providers or insurance company,

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**Financial and Insurance responsibilities:**

I agree to pay for my treatments at the time of service, by cash, check or credit unless other mutually agreed upon arrangements have been made. I understand it is my responsibility to call my insurance company ahead of time, and obtain any pre-authorization that is necessary, and get an estimate of my benefits. I understand my therapist will provide me with a receipt that is my responsibility to submit to my insurance company.

I have read the above information and I consent to physical therapy evaluation and treatment.

Print Name \_\_\_\_\_

Date \_\_\_\_\_

Patient or guardian Signature \_\_\_\_\_

Therapist Signature \_\_\_\_\_