ADVANCED ORTHOPAEDICS AND SPORTS MEDICINE-THERAPY SERVICES
PATIENT CONSENT FORM

ATTENDANCE POLICY: We are pleased to provide you high quality outpatient services. Every attempt is made to schedule your services in a timely manner and when possible, at your convenience. Because of the demand for services at this location, and to ensure positive therapeutic outcomes, we cannot reserve therapy time for persons who do not maintain a consistent attendance. Hence

- Cancellations must be made at least 24 hrs in advance. Patients who no show for 3 consecutive visits will be discharged with notice sent to you and your referring physician.
- Patients who miss 3 scheduled appointments in a 30 day calendar day period or 5 scheduled appointments in a 60 day calendar day period will be automatically removed from the active treatment schedule with notification sent to you and your referring physician.
- Patients more than 15 minutes late may be required to reschedule their appointments. Patients more than 15 minutes late to three or more treatments sessions without notice may be removed from the active treatment schedule with notification sent to you and your referring physician.

Exceptions to the aforementioned policy are considered on a case by case basis. If you have any questions or feel you have a situation that requires special consideration; please contact the front office as soon as possible.

PROHIBITION OF DRUGS, ALCOHOL, AND WEAPONS: I understand that Advanced Orthopaedics and Sports Medicine policy prohibits consumption, use or possession of non-prescribed drugs (including controlled substances, such as marijuana, cocaine and heroine), alcohol and weapons on any Advanced Orthopaedics and Sports Medicine properties. If non-prescribed drugs, alcohol, or weapons are found, they will be confiscated, and I may be discharged immediately. Local police authorities will be notified, if appropriate.

TOBACCO FREE ENVIRONMENT: I am aware that all Advanced Orthopaedics and Sports Medicine facilities are tobacco-free environments and that use of any tobacco product, except in designated areas, is strictly prohibited.

PERSONAL ITEMS: I have been advised to leave my personal items at home and assume responsibility for any personal items that I take to my treatment area. I understand that Advanced Orthopaedics and Sports Medicine and its facilities will not be responsible for any personal items that are lost, stolen or damaged.

NOTICE OF PRIVACY ACT, HIPAA: I acknowledge that I have received a copy of the Joint Notice of Privacy Practice and/or that I have had the opportunity to review it and ask questions. If I refuse to accept receipt of Joint Notice, I acknowledge that a good faith effort was made to present me with this document and my reason to refusing to accept this section and receipt of Joint Notice is _____.

CONSENT OF TREATMENT: I have been informed of my plan of care by my physical therapist and agree to the proposed treatment. We discussed my goals for physical therapy and I understand they will be addressed in treatment. I understand I may be sore following my physical therapy treatments, but realize that this is a common side effect to proper healing and increasing strength and flexibility. I appreciate that the achievement of a successful outcome is dependent upon my compliance with the scheduled visits ad exercises prescribed by my physical therapist. I have been informed of alternatives, possible side effects and adverse effects of not receiving prescribed treatments. I consent to all treatments deemed necessary by my physical therapist.

THIS CONSENT IS VALID UNTIL REVOKED OR CHANGED. I CERTIFY THAT I HAVE READ THE ABOVE INFORMATION, OR THAT THE ABOVE INFORMATION HAS BEEN READ OR TRANSLATED TO ME, AND THAT I UNDERSTAND MY RIGHTS AND OBLIGATIONS AS A PATIENT AT AN ADVANCED ORTHOPAEDICS AND SPORTS MEDICINE FACILITY.

_____ _____

Signature of Patient (or Patients representative) Date

_____ _____

Signature of Therapist (PT/OT) Date