Welcome to FUTURES REHAB Physical Therapy
We thank you for selecting FUTURES REHAB for your physical therapy needs.

Practice Policies

Consent for Treatment: I do hereby give consent for Physical Therapy and/ or Wellness related services at FUTURES REHAB. I understand there are no guarantees to the result of treatment. I have been given the opportunity to ask questions and have them answered to my satisfaction. _____(Initials)

Prescriptions Not Needed for the first 45 days or 12 visits: You have access to Physical Therapy and Wellness Services without the need for a Physician Prescription. This speeds your recovery and saves unnecessary costs and time required to visit an MD before accessing needed PT services. (Please note the official policy regarding direct access). If continuing therapy is needed, a Physical Therapy Plan of Care must be signed by the MD, after a qualified visit. _____ _____(Initials)

Payment for Services: FUTURES REHAB is a Cash-Pay and Out-of-Network therapy provider, as this is the fastest way to speed your recovery and prevent the burden of authorization delays, slow or unpaid reimbursements by Insurance companies. Given high co-pays, deductibles and the like, FUTURES REHAB services can achieve your goals and needs much faster, with minimal and sometimes no cost increases. This approach to service allows us to provide the physical therapy in a highly personalized fashion, typically not possible under reduced insurance reimbursement rates. We can provide a super bill for commercial insurances, upon request, that you may submit to your insurance company. WE DO NOT GUARANTEE REIMBURSEMENT FROM YOUR INSURANCE. _____(Initials)

Thank you for taking care of payments at the time of each service: _____(Initials)

Scheduling, Re-Scheduling - Cancellation and No-Show Policy: In order to secure the appointments times you desire, and in order to assure the fastest possible recovery and your goal achievement, please schedule through at least two (2) weeks of appointments, or up to the length of the Plan of Care, which you will be developing with your Physical Therapist. Re-scheduling requires 24 hour notice, in order that time can be utilized for another patient. Our office requires a 24 hour notice for cancelling an appointment. If cancellation or re-schedule is not 24 hours or greater, in advance, you will be charged a $50 cancel/no-show fee. _____(Initials)

Medical Records Release: I authorize release of my medical records or any information pertinent to my treatment to a referral source, physician, or other parties at your request. _____(Initials)

☐ **Notice of Privacy Policies Provided to Patient and Reviewed**

I have read and accept all of the above. My signature and date confirm acceptance of each of the above practice policies and my sole financial responsibility for the treatment services provided.

Signed: ____ **Date:** ______________
Patient or Guardian Signature, please circle appropriate

Patient Name Printed: ____