ANDERSON
PHYSICAL THERAPY
PERSONALIZED CARE FOR LASTING RESULTS

Consent to Treat & Financial Agreement

Patient Name: _____ **Date of Birth:** _____

Address: _____

Phone Number: _____ **Email:** _____

Consent to Treat:
I, the undersigned, authorize Anderson Physical Therapy to provide physical therapy services deemed necessary for my care. I understand that physical therapy includes evaluation, treatment, and follow-up care tailored to my specific needs.

Financial Agreement:
I acknowledge that Anderson Physical Therapy operates as a cash-based practice and does not bill insurance or Medicare for services rendered. I agree to pay for all services at the time of service unless otherwise arranged. I understand that I am responsible for submitting receipts to my insurance company if I choose to seek reimbursement.

Cancellation Policy:
I agree to provide at least **24 hours'** notice if I need to cancel or reschedule an appointment. **Missed appointments or late cancellations will be subject to a cancellation fee of $50.**

Patient Signature: _____ **Date:** _____

Therapist Signature: _____ **Date:** _____

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Medical History & Intake Form

Patient Name: _____ Date of Birth: _____
Emergency Contact: _____ Phone Number: _____

Primary Complaint/Reason for Visit: _____
When did symptoms begin?: _____
Have you received physical therapy for this issue before? Yes / No

Medical History (Check all that apply):

- Heart Conditions
- Presence of Pacemaker
- Diabetes
- High Blood Pressure
- Osteoporosis
- Thyroid Disease
- Autoimmune Disorder
- High Cortisol
- Joint Replacements
- Other (please specify): _____

Medications Currently Taking: _____

Previous Surgeries: _____

Smoking Status:_____

Alcohol Use:_____

Allergies: _____

Current Exercise Habits:_____

Goals for Physical Therapy: _____

Patient Signature: _____ Date: _____

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Liability Waiver & Informed Consent

I, the undersigned, acknowledge that I have voluntarily sought physical therapy services from Anderson Physical Therapy. I understand that there are inherent risks associated with physical therapy, including but not limited to muscle soreness, aggravation of existing symptoms, and injury. Physical therapy is a patient care service that is provided in order to manage a wide variety of conditions. The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis and intervention by use of rehabilitative procedures, mobilization, massage, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them.

Response to physical therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. Anderson Physical Therapy does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury.

It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

I have read this consent form and understand the risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care. I have been given an opportunity to ask questions, and all my questions have been answered to my satisfaction. I confirm that I have read and fully understand this consent form. In the event of a change in medical status, I understand that my treatment may be modified, stopped, or referred out to the proper practitioner. I reserve the right to withdraw at any time.

I agree to release Anderson Physical Therapy and its therapists from any and all liability, claims or damages, demands, or causes of action arising from my participation in treatment.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Patient Signature: _____ **Date:** _____

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Privacy Notice

Effective Date: 3/29/25

Your Privacy Rights

At Anderson Physical Therapy, we are committed to protecting your personal health information (PHI) in compliance with the Health Insurance Portability and Accountability Act (HIPAA). This Privacy Notice explains how we use, disclose, and safeguard your PHI.

How We Use and Disclose Your Information

We may use and share your PHI in the following ways:

- For Treatment: To provide, coordinate, or manage your physical therapy care.
- For Payment: To bill and collect payment from you or your insurance provider.
- For Healthcare Operations: To improve our services, train staff, and ensure quality care.
- As Required by Law: We may share information if required by federal, state, or local law.

Your Rights Regarding Your Health Information

You have the right to:

- Request copies of your medical records.
- Ask us to correct any incorrect or incomplete information.
- Request restrictions on certain uses or disclosures of your PHI.
- Receive a list of certain disclosures we have made of your information.
- File a complaint if you believe your privacy rights have been violated.

How We Protect Your Information:We take appropriate measures to safeguard your PHI from unauthorized access, use, or disclosure.

Contact Information: If you have any questions about this Privacy Notice or your rights, please contact us: Office Address: 520 Suite A111 Fellowship Road, Mount Laurel, NJ 08054

Email: Andrea@andersondirectpt.com

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HIPAA Privacy Notice & Consent

I acknowledge that I have been provided with Anderson Physical Therapy's Privacy Notice, which details how my protected health information may be used and disclosed under HIPAA regulations. I consent to the use and disclosure of my health information as outlined in the Privacy Notice.

Patient Signature: _____ **Date:** _____