The Craniofacial and TMJ Institute

(Bluegrass Doctors of Physical Therapy, PLLC)

Patient Agreement

Consent for Treatment: I have a condition requiring physical therapy intervention, and consent to the delivery of such care. In order to improve my physical condition in regards to pain, range of motion, strength or another type of physical impairment, I consent to commence the office of The Craniofacial and TMJ Institute program for evaluation and treatment. I request and authorize the licensed staff of The Craniofacial and TMJ Institute to render treatment and to perform appropriate procedures that my provider may deem reasonable and necessary for my diagnosis. I understand that my physical therapy care and treatment will be provided by a doctor of physical therapy. I am aware that there are certain risks involved with a physical therapy program. These risks include but are not limited to; exacerbation of current condition, organ puncture, dermal and sub-dermal burns, pneumothorax, hematoma, fractures, joint damage, nose bleeds, stroke or even death in the most rarest of cases. Every effort is made to minimize my risk by continuous assessment of my condition throughout my therapy. I will inform my doctor of physical therapy of any changes in my medical condition, or medications, as they may necessitate change in my therapy program. _____ (initials)

I will stop any procedure or activity and inform my therapist of any symptoms of pain, fatigue, shortness of breath, rapid heart rate, dizziness or nausea that may develop during my treatment. _____(initials).

Privacy Notice Acknowledgement: I understand that The Craniofacial and TMJ Institute will maintain my privacy to the highest standards and may use or disclose my health information for the sole purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment and/or payment**.** _____(initials).

Appointments/Cancellations: The Craniofacial and TMJ Institute requires 24 hours notification of cancellations. In the event I cancel a regularly scheduled appointment with less than 24 hours notice or I am not present or available for a scheduled appointment I will incur a full session fee. If there are 3 consecutive lapses in scheduled attendance I may be removed from the therapist's schedule & will have terminated this agreement. _____(initials)

Insurance: I understand that The Craniofacial and TMJ Institute is a fee for service physical therapy provider and <u>The Craniofacial and TMJ Institute will **not** bill my insurance company directly.</u> Further, I understand that I am responsible for asking for an itemized receipt from The Craniofacial and TMJ Institute which I may provide to my insurance company, if I have insurance. I understand that I am considered a ***self pay patient*** and I am financially responsible for the total amount of the services provided. The Craniofacial and TMJ Institute does not verify insurance coverage prior to providing services and does not guarantee reimbursement for services from my insurance company. _____(initials)

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Payment: I understand that I am considered a ***self pay patient*** and am responsible for payment at the time of service. Billing will appear on my credit card or debit under the name of Bluegrass Doctors of Physical Therapy. _____(initials)

Attire: For access to particular body parts being treated, loose fitting clothing is recommended. If your evaluation includes a diagnosis that involves an assessment of the lumbar spine and or pelvis, this may require you to change clothing and wear a gown. _____(initials)

Adult Supervision: Those under the age of 17 receiving treatment by The Craniofacial and TMJ Institute must be accompanied by a parent or legal guardian during each physical therapy appointment. _____(initials)

Other Information: I understand I may also be charged for therapy products, educational materials and for other administrative expenses, including copies of medical records, & that I will be notified of these charges at the time of service. _____(initials).

Bluegrass Doctors of Physical Therapy: I understand that if I am seeking services through Bluegrass Doctors of Physical therapy that The Craniofacial and TMJ Institute is affiliated with Bluegrass PT. All documents will state the name The Craniofacial and TMJ Institute as of August 2022. _____(initials)

PATIENT'S SIGNATURE

This agreement must be signed by The Craniofacial and TMJ Institute patient/client unless the patient/client is a minor, incompetent, or physically incapable of signing. I have read and fully understand the content of this two-page Patient Agreement and hereby agree to and authorize the foregoing provisions.

As used in this document, the terms "I', "me" and "my" refer to and include, in addition to the undersigned, the patient/client named above and others for whom the undersigned is responsible or for whom the undersigned has assumed responsibility in engaging The Craniofacial and TMJ Institute to provide services to the patient/client.

By signing this agreement, I acknowledge that I have read, understand and agree to the above terms and conditions

Patient Signature:_____Date:_____