

Andrus Physical Therapy, LLC
232 Norwood Avenue, Suite 1C
West Long Branch, NJ 07764
Phone: (732) 923-1500 Fax: (732) 923-1510

CONSENT TO PHYSICAL THERAPY TREATMENT

PATIENT NAME: _____ DATE: _____

1. I have presented myself for physical therapy treatment to Andrus Physical Therapy, LLC and consent to examination and treatment provided by my attending physical therapist.
2. I have the right to refuse or decline any examination, treatment, or procedures to the extent permitted by law in the state of New Jersey. I acknowledge the medicine/physical therapy is not an exact science; no guarantees or warranties can be made regarding the result(s) of my treatment at Andrus Physical Therapy, LLC.
3. I consent the release of copies of my examination and/or treatment records to referring physician(s) and/or third party payer (insurance companies) for the sole purpose of communication between Andrus Physical Therapy, LLC and the referring physician(s) and in order to properly process claims associated with my treatment. I also understand that I must give separate, written consent to allow Andrus Physical Therapy, LLC to release copies of my treatment records to any other parties (attorneys, non-referring physicians, etc.)

PATIENT SIGNATURE: _____ DATE: _____

If patient is a minor or unable to consent:

RESPONSIBLE PARTY SIGNATURE: _____ DATE: _____

RELATIONSHIP TO PATIENT: _____

REASON UNABLE TO CONSENT: _____

NO SHOW POLICY

By signing, I agree to the following no show policy:

There will be a \$10 service fee for each no showed appointment. I understand I am responsible to pay this fee if I do not call and cancel my appointment prior to the scheduled appointment time. I also understand that all my future appointments may be cancelled if I no show for 3 consecutive visits.

THIS POLICY IS EFFECTIVE JUNE 15, 2006.

PATIENT SIGNATURE: _____ DATE: _____

YOU MAY REQUEST A COPY OF THIS POLICY FOR YOUR RECORDS