360º Physical Therapy, Inc.

Informed Consent

The purpose of physical therapy is to treat injury and general disability by examination, evaluation, diagnosis, prognosis and intervention by use of rehabilitative procedures which may include joint or soft tissue mobilization, neuromuscular or therapeutic exercises, and modalities 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. You are free to question or decline any interventions in which you prefer to not participate.

I consent to receive outpatient rehabilitation therapy services and any ancillary services that are deemed medically necessary or appropriate by my physical therapist and/or treating physician.

In conjunction with my care, I consent to allow the use of filming devices, such as a camera or cell phone, for the purposes of education, movement analysis, and in concordance with the established plan of care. I understand these images will not be used in any other manner without my prior written consent.

HIPPA Notification and Licensure Verification

I acknowledge I have received information regarding 360º Physical Therapy's compliance with the Health Insurance Privacy and Portability Act and notification of licensure verification and complaint reporting as required by the Physical Therapy Board of California.

Cancellation Policy

Due to the complicated nature of scheduling for location specific appointments, last minute changes in the schedule greatly impact my planning and ability to commit to other individuals needing care.

I kindly request a **minimum of 48-hours notification** for the cancellation or change in schedule for all appointments. There will be a cancellation fee of $300 assessed in the event of a cancellation with less than 48-hours notice. This fee is not covered by insurance.

To cancel or change your appointment, please call or text 650.542.0189

Patient Name: _____ DOB: _____

Signature of Patient/Guardian: _____ Date: _____

360º Physical Therapy, Inc.

Contact Information

Patient name: _____

Address: _____

Phone number: _____

Contact Consent

The following individuals are allowed to receive information regarding my schedule:

Name: _____

Relationship: _____

Contact information: _____

Name: _____

Relationship: _____

Contact information: _____

Medical Information Sharing Consent

The following individuals are permitted to discuss my personal medical condition/s as it relates to physical therapy care:

Name: _____

Relationship: _____

Contact information: _____

Name: _____

Relationship: _____

Contact information: _____

360º Physical Therapy, Inc.

Telehealth Informed Consent

1. I understand that my health care provider wishes me to engage in a telemedicine visit.
2. My health care provider has explained to me how the video conferencing technology will be used to affect such a visit will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.
5. I have had the alternatives to a telemedicine visit explained to me.
6. In an emergent situation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the video conference connection.
7. I have had a direct conversation with my doctor, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

Patient Name: _____ DOB: _____

Signature of Patient/Guardian: _____ Date: _____