Cynergy Physical Therapy

CONDITIONS & CONSENT FOR PELVIC FLOOR PHYSICAL THERAPY EVALUATION AND TREATMENT

Cooperation with treatment:
I understand that in order for physical therapy treatment to be effective, I must come to scheduled appointments unless there are unusual circumstances. I understand and agree to cooperate with and perform the home physical therapy program intended for me. If I have trouble with any part of my treatment program, I will discuss it with my therapist.

Cancellation Policy
I understand that if I cancel more than 24 hours in advance, I will not be charged. I understand that if I cancel less than 24 hours in advance, I will pay a cancellation fee of $25.

No warranty: I understand that there are no guarantees regarding a cure for or improvement in my condition. I understand that my physical therapist will outline and discuss goals of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

Informed consent for treatment:
The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to you. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition.

I acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor dysfunctions which include but are not limited to bladder, bowel, sexual dysfunction, urinary and fecal incontinence, pelvic pain conditions, postpartum dysfunctions, post-surgery complications, sacroiliac, low back, coccyx pain syndromes.

I understand that to evaluate and treat my condition it may be necessary to have my therapist perform an internal pelvic floor muscle examination and treatment which is performed by observing and/or palpating the perineal region including vagina and/or rectum. Evaluation and treatment include assessment of skin, reflexes, muscle strength and tone, function of pelvic floor, observation, palpation, use of vaginal or rectal sensors for biofeedback and or electrical stimulation, ultrasound, heat, cold, therapeutic exercises, soft tissue and joint mobilization, educational instructions, visceral manipulation.

Potential risks: You may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury or condition. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my physical therapist.

Potential benefits: May include an improvement in my symptoms and an increase in my ability to perform daily activities. You may experience increased strength, awareness, flexibility and endurance in my movements. You may experience decreased pain and discomfort. You will have a greater knowledge about managing my condition and the resources available to me.

Alternatives: If you do not wish to participate in the therapy program, you will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

Release of medical records:
I authorize the release of my medical records to the following persons or professionals:

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Financial and insurance responsibilities:
Cynergy Physical Therapy provides physical therapy on a "fee at time of service" basis. By removing Cynergy Physical Therapy from the insurance companies, it does not have to limit the time or quality of treatment provided because of insurance company restrictions or elevate our rates to pay for billing services. I understand that I, the patient, am entering into care as a "cash-pay" client. By signing this agreement, I understand the Cynergy Physical Therapy will not be billing my insurance. I understand that my reimbursement benefits for Physical Therapy received at Cynergy Physical Therapy are out-of-network services and reimbursement is not guaranteed.

Medicare Patients: You will be required to sign a form (ABN) agreeing not to submit charges to Medicare and requesting that we do not. Because Medicare does not cover the care methods, treatment duration, diagnoses we treat, chronic

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issues, or wellness care, we are not enrolled providers and cannot submit claims to Medicare. Therefore, by choosing our services, you are exercising your right to privacy and electing, of your own free will, not to use your Medicare benefits. As such, you are agreeing to pay cash at the time of service for all services you elect to receive from us with no expectation that Medicare or your Medicare Supplemental Insurance Plan will reimburse you. You understand that we will not submit claims to Medicare on your behalf or provide you with a statement or billing codes that you can submit to Medicare yourself. If you want Medicare to pay for services that might be considered covered benefits, you should seek those services from a Medicare enrolled provider. If you decide at any point after you start services with us that you want Medicare to pay for the services it covers, we will be happy to recommend a Medicare enrolled provider and terminate your services with us. You also understand that since we are not enrolled Medicare providers, our services are *not* subject to Medicare's maximum allowable charge. You agree that you, your caregivers, family members, authorized representatives or power of attorney will not, under any circumstance, submit our claims, invoices, receipts or statements to Medicare for reimbursement or to obtain a denial for a Medicare supplemental insurance plan.

I agree to pay Cynergy Physical Therapy for my treatments at time of service, by cash or, check unless other mutually agreed upon arrangements have been made.

I have read the above information, informed my therapist of any condition that would limit my ability to have evaluation or to be treated, and I consent to physical therapy evaluation and treatment. I have asked any questions and they have been answered to my satisfaction. I understand the risks, benefits and alternatives to treatment. I hereby voluntarily consent to physical therapy treatment. I understand that I may choose to discontinue treatment at any time.

Print Name	Date
Patient or guardian signature	Therapist signature / Date

******If you are pregnant, have infections of any kind, have vaginal dryness, are less than 6 weeks post-partum or post-surgery, have severe pelvic pain, sensitivity to KY jelly, vaginal creams or latex, please inform the therapist prior to pelvic floor assessment.***