Be Still Physical Therapy, PLLC

360 South Monroe Street #524 Denver, CO 80209
720-385-8700

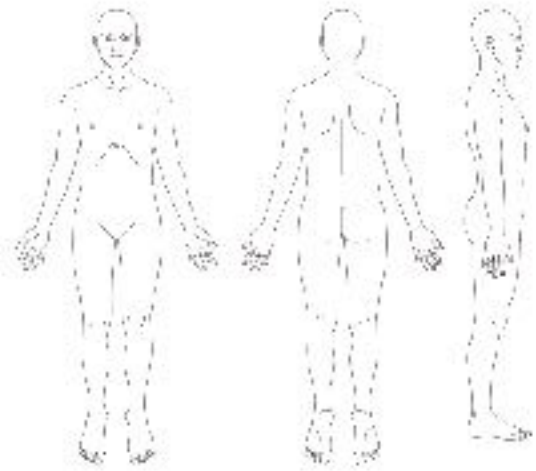
Consent to Treat

I hereby give Be Still Physical Therapy, PLLC, consent to furnish physical therapy care and treatment considered necessary and proper in diagnosing and/or treating my physical condition. I have stated all medical conditions I am aware of and will keep my practitioner informed of any changes. I give Be Still Physical Therapy permission to leave phone messages regarding my physical therapy care at the numbers listed below. This consent will remain valid until revoked in writing.

Patient name:_____ Date:_____

Phone/cell #:_____

Email:_____



What is primary area of concern/pain? (Circle areas on diagram)

Surgeries: _____

Car accident(s):_____

Fall(s)/Concussion(s):_____

Old Injuries:_____

Disturbed sleep: Y or N

Financial Policies

1. Be Still Physical Therapy, PLLC is an out-of-network physical therapy provider and considered a fee-for-service facility. This means that payment is expected in full at the time of service. Be Still Physical Therapy, PLLC ***does not*** directly bill health insurance companies however, upon request, we will provide you with a treatment invoice of services rendered.
2. Patients will be responsible to submit treatment invoices to their health insurance company for member reimbursement for out-of-network physical therapy services. If you do plan to submit for reimbursement, it is important to check with your insurance provider as some require pre-authorization, a physician prescription or do not cover out-of-network providers.
3. Be Still Physical Therapy, PLLC cannot guarantee reimbursement for services provided.

Cancellation/No Show Policy

1. All patients must provide 24 hour notice in order to reschedule or cancel an appointment. Note that your appointment time is reserved especially for you, hence late cancellations without valid reason will be charged ***50% of that visit's fee***.
2. No-show to a scheduled appointment will be charged ***100% of that visit's fee***.
3. Individuals that are more than 15 minutes late will be charged ***100% of that visit's fee*** and be required to re-schedule their appointment for another day.
4. Cancellation fees will be paid in full at or before next scheduled appointment.

Patient/Guardian Signature:_____ Date:_____