**Form Physical Therapy, LLC**

**Patient Rights and Responsibilities
Your therapist may review this information with you during the first appointment.**

Welcome to Form Physical Therapy, LLC! Whether this is your first Physical Therapy experience or you are a therapy veteran, there are a few things we would like to share with you to ensure the best possible care during our time together.

1. **Successful** therapy is an 80% (patient) / 20% (therapist) relationship. **Active** participation of both parties in this process is paramount to success in therapy. Physical Therapists are educators that provide TOOLS necessary to be successful on the road to recovery. Sometimes this is in the form of home exercises, simple postural corrections, or other suggestions. I only prescribe these if I think it would benefit you functionally. What you do at home enables me to accelerate your recovery while at the clinic. Without this active participation at home, you may only marginally improve. Remember: I see you for a very limited time each week, so you need to commit to your recovery in order to make improvements in the long run.
2. We respect your time and try to be as prompt as possible. **Please arrive on time for all appointments**. If you know you will be unable to attend an appointment, please provide at least a 24-hour notice, as many patients are frequently in need of additional therapy. Please note there is a $35 cancellation fee for appointments cancelled in less than 24 hours. (Active labor does not apply : )
3. Please schedule recommended follow-up appointments at the start of care as directed by your therapist. This clinic books quickly and I want to be certain there is no gap in your care that could result in less optimal outcomes.
4. You have the right to cancel therapy at any time during your care for any reason. If you are unsatisfied with your care, please let me know so I can recommend another clinic.
5. I have been given access to the HIPAA Notice of Privacy Practice.

I, (print name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have read the above rights and responsibilities and have actively discussed any questions with my therapist. I understand that my active participation in this process is paramount to my successful recovery.

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Medical Record Release

If you would like Form Physical Therapy, LLC clinicians to communicate with care providers outside of our physical premises please provide information and sign.

Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize release of information to this practitioner:

Signature:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_