PHYSICAL THERAPY INFORMED CONSENT AND LIABILITY RELEASE

1) Cancellation policy: If you cancel with less than 24 hours notice, or fail to show up for a scheduled appointment, a $35 fee will be assessed.

We will keep your credit card information on file for the purpose of charging late cancellations, should they occur. Should you choose not to have your credit card on file, a $50 deposit will be collected at your first visit, which will be refunded at the completion of your therapy, minus any late cancellation fees. _____ (initial)

2) It is highly recommended that you verify your Physical Therapy Benefits directly with your health plan, including but not limited to deductibles, co-pays, number of visits allowed, prescription/pre-authorization required. You agree to be held financially responsible for the treatment provided to you.

3) Our fee for a Physical Therapy Evaluation is $125, and PT treatment is $88. A reimbursement form (superbill) can be provided to you as documentation of your payments, which you may submit to your insurance provider or Health Savings Account.

4) Kindly turn cell phones and pagers off, or to vibrate, when entering the studio. We ask that you focus your attention on your session and value your time at KinetiCore.

5) KinetiCore Pilates Therapy shall not be liable for the loss or theft of, or damage to, the personal property of a client.

6) I give consent for KinetiCore Pilates Therapy to provide and perform therapeutic care, tests, procedures, and other services and supplies that are considered necessary or beneficial for my health and well-being. I understand that there are no guarantees regarding a cure for or improvement in my condition. *Potential Risks*: I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury or condition. *Potential Benefits*: May include an improvement in my symptoms and an increase in my ability to perform daily activities. I may experience increased strength, flexibility, endurance, and body awareness. I may experience decreased pain and discomfort. I should gain greater knowledge about managing my condition and the resources available to me. *Alternatives*: If I do not wish to participate in the therapy program, I will discuss my medical, surgical, or pharmacological alternatives with my primary care physician or specialist. _____ (initial)

7) By engaging in therapy at KinetiCore Pilates Therapy, you represent that you are physically able to safely participate in an exercise program, and have received physician clearance to participate. _____ (initial)

8) As with any exercise program, pilates carries with it inherent risks. KinetiCore Pilates Therapy shall not be liable for any damages arising from any personal injuries sustained by a patient on or about the premises of KinetiCore Pilates Therapy, or while following the prescribed exercise program (whether at home, health club, corporate, or other fitness facility). A patient, in attending KinetiCore Pilates Therapy and using its facilities and equipment, does so at his/her own risk. A patient assumes full responsibility for any and all injuries that may occur, excepting only an injury caused by gross negligence or intentional act. A patient does hereby fully and forever release and discharge KinetiCore Pilates Therapy, its owners, employees, and agents from any and all claims, actions, lawsuits and the like which he/she or his/her heirs, executors, administrators, or assigns may have or claim to have in connection with his/her participation in the therapy program. _____ (initial)

I have read and understand all of the above terms. At my discretion, I have printed a copy of the KinetiCore Pilates Therapy Physical Therapy Informed Consent and Liability Release for my records. I sign voluntarily and with full knowledge of its significance.

Printed Name _____ Date _____

Signature _____