



QUEEN CITY PELVIC PT
The Professional and Personal Care You Deserve

Name: _____
DOB: _____

PHYSICAL THERAPY INFORMED CONSENT, WAIVER & RELEASE OF LIABILITY

In agreeing to receive care provided by Queen City Pelvic PT, LLC, I agree as follows:

I fully understand and acknowledge that:

- (a) Although Queen City Pelvic PT (Ana Karim, PT) will evaluate and treat to the best of her abilities and skill to optimize my health and wellbeing, there are no guarantees that my condition will improve;
- (b) the activities in which I will engage as part of the treatment provided by Queen City Pelvic PT and the equipment I may use as a part of that treatment have inherent risks, dangers, and hazards and such exists in my use of any equipment and my participation in these activities;
- (c) my participation in such activities and/or use of such equipment may result in injury or illness including, but not limited to, bodily injury, disease, soreness, strains, numbness, tingling, muscle tears, fractures, partial and/or total paralysis, death or other ailments that could cause serious disability;
- (d) I hereby assume all risks and dangers and all responsibility for any losses and/or damages whether caused in whole or in part by the negligence or the conduct of the representatives or employees of Queen City Pelvic PT, or by any other person;
- (e) I know that I have the right to choose what treatment I do or do not receive, in addition to withdrawing from treatment at any time;
- (f) I recognize that my participation in the activity covered hereby is conditioned upon my signing and returning this waiver and release.

I, on behalf of myself, my personal representatives and my heirs, hereby voluntarily agree to release, waive, discharge, hold harmless, defend, and indemnify Queen City Pelvic PT and its representatives, employees, and assigns from any and all claims, actions or losses for bodily injury, property damage, wrongful death, loss of services or otherwise which may arise out of my use of any equipment or participation in these activities, or loss of any kind out of or resulting from my refusal to accept, receive or allow emergency and/or medical services including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services.

I specifically understand that I am releasing, discharging, and waiving any claims that I may have presently or in the future for the negligent acts or other conduct by the representatives or employees of Queen City Pelvic PT.

I understand that I may show this INFORMED CONSENT and WAIVER & RELEASE OF LIABILITY to, and consult with, my own independent legal counsel before signing.

Consent/Authorization of Treatment: I consent to and authorize Queen City Pelvic PT (including students in training) to administer physical therapy treatment under the direction and supervision of the physical therapist. I understand, acknowledge and affirm that such therapy services may involve verbal and written discussion of my medical history, bodily observation, and touch and/or direct contact of a sensitive nature.

I understand that to evaluate my condition it may be necessary, initially and periodically, to have my therapist perform an internal pelvic floor muscle examination. This examination is performed by observing and/or palpating the perineal region including the vagina and/or rectum. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, scar mobility, and function of the pelvic floor region. Such evaluation may include vaginal or rectal sensors for muscle biofeedback.

I understand and am informed that, as in the practice of medicine, physical therapy may have some risks. I understand that I have the right to ask about these risks and have any questions about my conditions answered prior to treatment. I know it is up to me to inform the physical therapist/staff about any health problems or allergies I have, as well as medications I am taking.

Termination of Services: I hereby acknowledge that my therapist can terminate services at any time for any reason without notice and my therapist acknowledges that the patient can terminate services at any time for any reason without notice and must cancel any remaining appointments. The patient understands that should the physical therapist determine that in their professional judgment, therapy is no longer necessary or helpful, the therapist reserves the right to withdraw and terminate treatment without notice. Termination can also occur:

- a) For nonpayment
- b) If the therapist feels unsafe or unsecure in the physical environment or with the patient
- c) For providing false information or misinformation regarding your medical history or physical condition, and
- d) If the parties disagree on the course of treatment

If the patient terminates treatment, the patient remains responsible for the payment of any outstanding monies owed for services already provided.

I HAVE READ THE ABOVE WAIVER AND RELEASE AND BY SIGNING IT, AGREE TO RECEIVE PHYSICAL THERAPY SERVICES FROM QUEEN CITY PELVIC PT. IT IS MY INTENTION TO EXEMPT QUEEN CITY PELVIC PT FROM LIABILITY FOR PERSONAL INJURY, PROPERTY DAMAGE OR WRONGFUL DEATH BY ANY CAUSE.

Patient/Representative Printed Name Patient/Representative Signature Date

Reason patient is unable or unwilling to sign: _____

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with a Notice of Privacy Practices which explains how Queen City Pelvic PT may use and disclose health information. I acknowledge that this notice has been made available to me. ___ **Initials**

I give Queen City Pelvic PT authorization to utilize this email address: _____

And/or this telephone number for calls and/or texts: _____ **Initials**

I give Queen City Pelvic PT permission to share personal health information with the following individual(s). They may serve as my healthcare agent(s) to act for me and in my name.

A. Name: _____

Home Address: _____ Home Telephone: _____

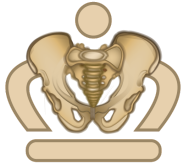
_____ Work/Cell Telephone: _____

B. Name: _____

Home Address: _____ Home Telephone: _____

_____ Work/Cell Telephone: _____

Patient/Representative Signature Therapist Signature Date



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PATIENT AUTHORIZATION FOR FINANCIAL STATEMENT

I understand that Queen City Pelvic PT does not accept insurance or file any claims for health insurance. Payment is due immediately upon the provision of services unless a previous arrangement has been made. All patients are required to pay total charges at the time of service. I agree that I am responsible for any and all charges incurred by physical therapy even if I have insurance.

FEES: Initial Evaluation \$180, Follow-up Treatment \$105, Telehealth Evaluation \$120, Telehealth treatment/follow up \$60/30 minutes.

QUEEN CITY PELVIC PT requests a valid credit card number to be kept on file at the time of scheduling your initial visit. Your card will not be charged until services rendered or unless a no-show or cancellation occurs according to policy below.

PATIENT CANCELLATION AND NO-SHOW POLICY:

We require 24-hour notice for cancellations. Appointments that are cancelled with less than 24 business hours' notice or in the event of no-show appointment you are subject to an \$70 fee.

In order to provide you with the best care possible we ask that you agree to this policy and make every effort to keep your scheduled appointments and arrive in a timely manner.

This policy has been established in order to provide the highest level of Physical Therapy Service to all of our patients. It has been proven that consistent attendance provides for the greatest opportunity for success. By providing us notice of cancellation, we may be able to accommodate other patients with your appointment slot. We do understand that emergencies arise and that it may not be possible to give such a notice. Exceptions to the No-Show/Late Cancellation Policy will be determined by Ana Karim, PT. If you need to reschedule or cancel an appointment, please call us as soon as you know you cannot make your scheduled appointment. We can be reached by phone/text at 704-665-7865.

*****MEDICARE Authorization of payment:** I hereby refuse submission of my personal health information, medical records and billing information from being sent to my insurance company under any circumstance. This decision is of my own free will and under no guidance of any other person. I understand that I am fully responsible for all financial obligations to Queen City Pelvic PT and cannot submit for reimbursement from my insurance company.

Initials _____ (if applicable)

Signature: By virtue of my signature below, I hereby acknowledge that I have read and understand all of the above, I agree to be bound by all of Queen City Pelvic PT billing and payment policies and that I have been given adequate opportunity to ask questions about the same.

I also authorize and request Queen City Pelvic PT to charge my card as indicated above for services from Queen City Pelvic PT. This authorization relates to all payments and charges I have been made aware of for services to be received at Queen City Pelvic PT. This authorization will remain in effect until I cancel this authorization. To cancel I understand I must provide a written request to Queen City Pelvic PT and my account must be in good standing.

I certify that all of the information provided here is true and correct. I understand I am responsible for any charges that may occur due to incorrect information given here.

Credit card type and #: _____ Exp: _____ CVC: _____
 Billing Address: same as mailing or: _____

Patient/Representative Signature

Therapist Signature

Date