MISSED APPOINTMENT POLICY

Thank you for choosing Strive Physical Therapy. Your therapy team will work with you to establish a plan of care to assist in reaching your therapy goals. Your adherence to the recommended number of treatments is a vital component of your progress toward those goals. With the exception of serious emergencies, it is expected that you attend all scheduled appointments. If you need to reschedule, please call our office and arrange a make-up appointment within the same week. We reserve the right to charge a $35 fee for no-showing or cancelling an appointment without 24-hour notice.

In instances of repeated non-compliance with your scheduled visits, we also reserve the right to discontinue care. Your physician will be informed that your service has been discontinued due to non-compliance with the prescribed rehabilitation order.

PHYSICAL/OCCUPATIONAL THERAPY TREATMENT CONSENT

I request and consent to the physical/occupational therapy evaluation and treatment performed by a licensed physical/occupational therapist or licensed physical/occupational therapist assistant of Strive Physical Therapy. I understand that the therapists will evaluate and determine the appropriate treatment procedure(s) specific to my presentation and condition. Treatment procedures will comply with the state's physical therapy practice act and may include manual therapy techniques, such as spinal and extremity manipulation/mobilization and instrument-assisted techniques (i.e., dry needling, cupping, ASTYM); neuromuscular re-education; therapeutic activities; therapeutic exercise; and modalities such as ultrasound, electrical stimulation, iontophoresis, and heat/cold therapy.

I understand that by participating in therapy there are potential risks to treatment that may include, but are not limited to fractures, disc injuries, cardiovascular issues, pneumothorax, bruising, increases in pain, burns, and nerve injury. It is not reasonable for the therapist or assistant to explain all risks at any particular visit, and I understand I have the right to ask questions and to terminate any part of the therapy treatment at any time.

I understand that the therapist or assistant will be using PredictionHealth's AI scribing software. This software will record and process the audio of our conversation to auto-generate documentation in my electronic medical record. The audio recording will be used for clinical purposes only and will not be used for any other purposes such as sharing, selling, or advertising. The audio recording will be stored securely as part of my medical record in accordance with the Health Insurance Portability and Accountability Act's security regulations. I agree and consent to this recording.

☐ I would like to opt out of the secure and encrypted AI scribing tool.

By signing below, I hereby acknowledge and agree that I have completely read and fully understand this Physical/Occupational Therapy Treatment Consent and Missed Appointment Policy form. I have had the opportunity to inquire about its content, and by signing below, I agree to the above-mentioned processes, procedures, and/or treatment.

Patient Name: **Signature**: **Date:**

Below required for treatment of a minor or patient who does not have their own power of attorney.

Name of Parent or Legal Guardian: **Signature**: **Date:**