WELLNESS REHABILITATION INC.
10410 Kensington Parkway, Suite 11, Kensington, MD 20895
www.wellnessrehab.org, 301-493-9257 cynthiaweiss@verizon.net

CONSENT and RELEASE for TELEHEALTH Physical Therapy

Patient Name:____________________________________ DOB:____________________
Address:____
____
Phone: (Home)________________________ (Work)__________________________
(Cell)_________________________ (email)________________________________
In case of emergency contact:____

Please read carefully before you sign. By your signature, you acknowledge understanding of all items set forth herein.

Consent to Physical Therapy Services

I give my consent to allow Cynthia Weiss, P.T. to evaluate and treat me per my diagnosis and referral from my physician. I, ____(print your name), consent to the procedures which may be performed during the duration of physical therapy treatment. I understand that the rehabilitation process, by its very nature, involves certain inherent and unavoidable risks, including falls and other similar injuries, and that the only alternative to entirely avoid these risks would be to forego rehabilitation altogether.

I understand that telehealth is the use of electronic information and communication technologies by a healthcare provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to Wellness Rehabilitation Inc. providing health care services via telehealth.

I understand that the laws that protect privacy and confidentiality of medical information also apply to telehealth.

I understand that I am a client of Wellness Rehabilitation Inc. and I will be receiving my treatment via TELEHEALTH on a secure online platform.

I understand that I will be given home exercise program and home tips to allow me to progress towards my goals.

Informed consent for treatment: The term "informed consent" means that the potential risks, benefits and alternatives of physical therapy treatment have been explained to me. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition.
Potential risks: I understand that the rehabilitation process, by its very nature, involves certain inherent and unavoidable risks, including falls and other similar injuries, and that the only alternative to entirely avoid these risks would be to forego rehabilitation altogether. I agree to contact my physical therapist should I experience any increase in pain.

Potential benefits: I may experience an improvement in my symptoms and an increase in my ability to perform daily activities. I may experience increase strength, awareness, flexibility, and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

Guarantee of Payment/Release of Information and Billing Authorization: I understand that I am responsible for full payment for this session. If I have already paid for a package, these sessions will go towards those packages. Wellness Rehabilitation Inc. is an out of network provider. I understand that I am able to bill my insurance for this session, unless these sessions are considered only Pilates/exercises and we agreed to go in that direction versus PT sessions, and I have checked with my insurance provider for possible reimbursement. I also understand should I need to cancel, **Wellness Rehabilitation Inc. requires 24 hour notice or fee for treatment will be charged.**

I authorize Wellness Rehabilitation Inc. to furnish medical records information pertaining to my diagnosis and treatment to other treating physicians, health care providers, institutions, and my insurance carriers and their agents as specified on this document. I give my consent to allow Cynthia Weiss, PT to discuss my case with my physicians and any other health care professional as needed to provide me the best quality of care.

I have read the above information and I consent to physical therapy evaluation and treatment or Pilates/exercise sessions.

By electronically signing, I confirm that I have read all of the above information and I consent to physical therapy evaluation and treatment or Pilates/exercise.

Insurance Information

Primary Insurance _______________________________ Insurance Number_______________________
Secondary Insurance ______________________________ Insurance Number_______________________

Physician Information

Name __________________________________ Name ________________________________

Address___________________________________ Address ______________________________

___________________________________ _______________________________
___________________________________ _______________________________

Patient Signature ___________________________ Date __________________

____ _______________________
Parent/Guardian Signature (if minor) Date