PATIENT AGREEMENT

Please refrain from wearing perfumes, aftershaves or other scents to the office. Thank you.

Consent

I hereby give my permission to be evaluated and treated by Diamond Physical Therapy Associates, PC. I understand that I will receive information at the initial evaluation concerning treatment options available for my condition. My therapist will also discuss the potential risks, benefits and alternatives to the proposed treatment, and treatment goals. I understand that I may discontinue treatment at any time.

Release

I hereby authorize Diamond Physical Therapy Associates, PC to release medical information as required by my insurance company to insure my insurance benefits.

Payment

Payment in full, by cash or check, is expected when services are rendered.

Appointments

Cancellation can be done by text or email and will be confirmed. I understand that if I am unable to keep an appointment, 24 hours notice is required. If I cannot comply with this policy, and I cancel less than 24 hours in advance of my scheduled appointment, I will be charged $135.00 for the visit. These fees cannot be billed to my insurance company.

Facility

I understand that Diamond Physical Therapy Associates, PC does not own the facility at which I receive treatment and that Diamond Physical Therapy Associates, PC is not responsible for the operation, maintenance and repair of the facility. Therefore, I agree that I shall not hold Diamond Physical Therapy Associates, PC responsible for any illness, injury or other condition that I may incur as a result of or related to the operation, maintenance and repair of the facility.

Patient Signature: _____ **Date:** _____

Patient Name: _____
(please print)

Signature of Legal Representative: _____ **Date:** _____

Print Name: _____ **Relationship to Patient:** _____