CONCIERGE PHYSICAL THERAPY AGREEMENT

CLIENT NAME: _____ DOB: _____ RESPONSIBLE PARTY: _____
If client is a minor.
ADDRESS: _____
PHONE #: _____ E-MAIL ADDRESS: _____
EMERGENCY CONTACT & PHONE #: _____ RELATIONSHIP: _____

Consent to Treatment ____*(initials)*

I recognize that any and all physical therapy services and treatment available to me are not based on medical necessity but are provided based on my volitional request to obtain these services. I hereby consent to the rendering of physical therapy services by Quozette Valera of DRQDPT. I understand that the practice of physical therapy is not an exact science and that physical therapy treatment involves the risk of injury. I acknowledge that no guarantees have been made to me about the outcome of treatment. I voluntarily request the right to participate in the in-home physical therapy services provided by DRQDPT. I recognize, understand, and accept that the services administered may include, but are not limited to the following:

- Complete physical evaluation and assessment (externally, and internally, for pelvic floor rehabilitation)
- Manual treatment interventions (soft tissue, connective tissue, scar tissue, myofascial, visceral, and joint mobilizations, myofascial decompression/cupping, IASTM, manipulations, etc)
- Therapeutic exercise (progressive resistance strengthening, endurance training, etc)

Treatment of Minors ____*(initials)*

I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. I recognize and understand that any education or information given throughout the course of physical therapy treatment is not meant to replace any medical advice from my pediatrician or any other medical professional involved in the care of the specified minor, and will not be misconstrued as such.

Waiver & Release of Liability (attached) ____*(initials)*

I have read and understood the Waiver & Release of Liability form and agree to abide by the outlined provisions.

Cancellation Policy ____*(initials)*

In the event of an emergency, urgent matter, illness, or unforeseen circumstances in which the I am unable to keep any scheduled sessions, I shall notify Quozette Valera of DRQDPT as soon as possible. I understand that any arrangements to cancel or reschedule an agreed upon session must be made with at least 24 hours notice in order to avoid a penalty. I understand that failure to give at least 24 hours notice will result in forfeiture of the scheduled session without refund, and any additional sessions scheduled in place of the cancelled session will require new payment.

Emergency Clause ____*(initials)*

I recognize and understand that in the event of an emergency, urgent matter, illness, or unforeseen circumstances in which Quozette Valera of DRQDPT is not able to provide physical therapy services already scheduled and paid for, the funds will be used toward a future session. If no future sessions are scheduled and/or I am not able to reschedule the missed session within 60 days of the original appointment, I understand that I am entitled to a full refund of my retainer fee.

Illness Clause ____*(initials)*

I recognize the right of Quozette Valera of DRQDPT to refuse services and reschedule the session(s) as needed in the event that she deems any members of the household as ill and/or contagious in order to protect her health and prevent contracting any illnesses that could be passed to other clients. In the event that either I or any member of the household begin to show symptoms of illness, I agree to notify Quozette Valera of DRQDPT immediately to reschedule the session(s). I recognize that all paid fees will be applied to future session(s), however failure to reschedule within 60 days of missed session will result in forfeiture of the retainer fee and any additional sessions will require new payment.

Financial Responsibility ____*(initials)*

I understand that I am financially responsible for all charges. I agree to pay a nonrefundable retainer fee of 50% of the total cost of services at the time of the signing of this contract in order to guarantee availability of Quozette Valera of DRQDPT and secure the preferred dates. I agree to pay the remaining balance prior to each session, or at the completion of the initial evaluation in the case of a package deal. I recognize, understand, and agree to abide by the following fee schedule:

- $275/evaluation (60min)
- $200/treatment session (60min) – **$150/session for infants & postpartum doula clients
- $700 package (evaluation +3 treatment sessions) – **$600 for infants & postpartum doula clients
- $900 package (evaluation +5 treatment sessions) – **$800 for infants & postpartum doula clients

Acknowledgement of insurance reimbursement policy: ____ *(initials)*

I acknowledge and understand that in order to receive insurance reimbursement, it is my responsibility to file any claims. I understand that I am entitled to a "super bill" invoice that can be submitted to my insurance company, and that any insurance reimbursement information quoted by Quozette Valer of DRQDPT is just an estimate, and may not reflect actual reimbursement amount. I understand that I am responsible for and agree to pay all charges, even those not reimbursed by my insurance.

Anticipated Needs, Availability & Fees ____*(initials)*

Physical therapy sessions are available after 6pm (Monday through Thursday), and all day Friday through Sunday (based on availability of Quozette Valera of DRQDPT). A minimum of 2 follow-up treatment sessions is recommended to maximize benefits of physical therapy. All physical therapy sessions are to be scheduled and agreed upon at the time of signing this contract. In addition to the rates outlined in the Financial Responsibility, I agree to pay the Distance Fee of an additional $10 per session when >20 miles of travel is required (+$5 for every 10 additional miles beyond initial 20).

IN-HOME PHYSICAL THERAPY EVALUATION = $275
TOTAL PT TREATMENT SESSIONS REQUESTED: _____ x $200/session = $____
INFANT/POSTPARTUM DOULA CLIENT DISCOUNT: ($50)/session x ____ sessions =($____)
DISTANCE FEE: ___ sessions x $__/shift = $____
GRAND TOTAL= $____
RETAINER FEE (50%) = $____

Postpartum doula clients interested in scheduling in-home physical therapy sessions have the option to schedule sessions during established and agreed upon doula hours, however itemized fees will apply for each individual service.

Arbitration Clause ____ *(initials)*

In the event of any controversy or claim arising out of or relating to this agreement, or a breach thereof, as well as any claim of medical malpractice, including any claim that any provided services were improperly, negligently, or incompetently rendered or omitted, the parties hereto shall first attempt to settle the dispute in accordance with the following Grievance Policy: I agree and understand that any complaint or expression of dissatisfaction regarding service delivery must be made in writing and submitted to DRQDPT and all attempts to resolve the situation will be made by the responsible parties. In the event that I am not satisfied with the outcome or a solution is not reached within 30 days of the written complaint, I understand any unresolved controversy or claim shall be determined by submission to binding arbitration, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. I understand that parties to this agreement, by entering into it, have agreed to the use of binding arbitration in lieu of having any such dispute decided in a court of law before a jury.

Negotiability of Contract Clause ____*(initials)*

I have read the aforementioned terms and provisions outlined in this agreement and understand that this contract is negotiable. I recognize my right to review this agreement and understand that I have the opportunity to consult with my own legal counsel as I deem necessary. Any negotiations shall be requested in writing and reviewed and agreed upon by all parties prior to signing.

CLIENT'S NAME (PRINT)	CLIENT'S SIGNATURE	DATE
PARENT/GUARDIAN'S NAME (PRINT) *If client is a minor.*	PARENT/GUARDIAN'S SIGNATURE	DATE
PHYSICAL THERAPIST'S NAME (PRINT)	PHYSICAL THERAPIST'S SIGNATURE	DATE

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