Restrictions Released
Myofascial Therapy

Informed Consent

I, _____ give my consent to physical therapy treatment provided by Megan Ciccolo, DPT. I understand that I have the right to refuse treatment at any time. I have the right to ask questions to fully understand my care. I understand that I may experience a temporary increase in pain or soreness as a result of treatment techniques. I understand that myofascial release techniques may possibly cause emotional releases. I have fully disclosed my medical history that would impact my treatment and I am willing to consult my doctor when advised to do so.

Payment Policy

Payment is expected at the time of service. Cash or check are preferred, however credit cards are also accepted. Health savings account (HSA) or flexible spending account (FSA) can be used for payment. If your insurance company is a PPO and allows for out of network providers you may be able to submit a bill to be reimbursed. If you plan to submit to your insurance company please discuss this with Restrictions Released prior to treatment. There are no guarantees that you will receive reimbursement, this is between you and your insurance company. Restrictions Released will not have any involvement with insurance companies.

Privacy Practice

Your medical information will be kept private. Restrictions Released will not share your personal or medical information with outside sources without your prior consent. You have the right to review your medical records and obtain a copy for a reasonable fee.

Cancellation Policy

Please give at least 24 hours notice if you wish to cancel your appointment, other patients may be waiting for an appointment. There will be a $50 charge for appointments cancelled with less than 24 hours notice.

I have read and understand the above policies.

_____

Signature Date
(If under 18 years old parent's signature)