OFFICE AND APPOINTMENT CANCELLATION POLICIES

- We request at least 24 hours' notice for any appointment changes or cancellations. **We reserve the right to charge a $75 missed appointment fee for any changes made with less than 24 hours' notice.**
- Direct all appointment needs through the front office by calling (802) 497-0736. Please do not email your PT with appointment questions or changes.
- Patients who frequently cancel or no-show may be discharged from care.

- We will check on your insurance coverage as a courtesy prior to or at your first visit. However, patients should understand their own coverage and be prepared to cover any costs associated with their care. VTPT does not guarantee the accuracy of information provided to us by your insurance company.
- Copays and self-pay patients are required to pay at time of service. We will bill patients with deductibles monthly.
- Patients who fail to satisfy their financial obligations to VTPT may be sent to collections.
- Patients with financial concerns should discuss them with the Front Office staff as soon as they arise – whenever possible, we will work with you to make sure you get the care you need.

- VTPT is required by law under the Privacy Regulations as stated in the Health Insurance Portability Act (HIPAA) to protect any personal or health-related information we collect from you. If you wish to review our full Notice of Privacy Policy for Protected Health Information policy, please ask for a copy from the Front Desk.

By signing below, you acknowledge you have been given the opportunity to read the above office policies, that they are clear to you and that you have been given the opportunity to ask any questions you may have concerning these policies.

Failure to abide by these policies may result in termination of care.

Printed Name: _____ Date: _____

Signature: _____
(parent or guardian if under 18)

CONSENT TO TREAT

To the patient: you have the right to be informed about your condition and the recommended physical, medical and/or diagnostic procedure to be used so that you make the informed decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved.

In order to provide any sort of medical care to you, you as the patient must willingly consent to said care and any evaluation done prior to beginning your care.

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that:

1) You intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment is recommended; and

2) You consent to treatment at this office or any other satellite office under common ownership; and

3) This consent will remain fully effective until it is revoked in writing.

You have the right to discuss your treatment plan with your healthcare provider. Any concerns regarding testing or treatment should be discussed with your healthcare provider.

I voluntarily request a Physical Therapist or the designees deemed as necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this medical practice.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Printed Name: _____ Date: _____

Signature: _____
(parent or guardian if under 18)

MEDICAL HISTORY

Do you or have you experienced any of the following?

Alzheimer's	Y	N	Abnormal Menstrual Cycles	Y	N
Cardiovascular Disease	Y	N	Pelvic Inflammatory Disease	Y	N
Cerebral Vascular Accident	Y	N	Other reproductive issues	Y	N
Current Infection	Y	N	Currently Pregnant	Y	N
Diabetes Type 1 OR II	Y	N	Complicated Pregnancies	Y	N
Fibromyalgia	Y	N	Alcoholism	Y	N
Fracture/Suspected Fracture	Y	N	Blood Disorders	Y	N
High Blood Pressure	Y	N	Chest Pain/Shortness of Breath	Y	N
Hx of Cancer	Y	N	HIV +	Y	N
Immunosuppressed	Y	N	Impaired Hearing	Y	N
Muscular Dystrophy	Y	N	Impaired, uncorrected vision	Y	N
Osteoarthritis	Y	N	Joint Pain/Swelling	Y	N
Parkinson's	Y	N	Lung Disease	Y	N
Rheumatoid Arthritis	Y	N	Neurological Disorder	Y	N
Traumatic Brain Injury	Y	N	Recent weight loss/gain	Y	N
			Thyroid Condition	Y	N
			Urinary/bowel Incontinence	Y	N
			Psychological Disorders	Y	N
			Other: _____	Y	N

Height/Weight: _____ft/in, _____lbs

Please list all medications you are currently taking or provide us with a separate med list:

Medication	**Dosage/Frequency**	**Reason**

Any known allergies/sensitivities? _____

Please list all surgeries with approximate dates:

_____

_____

Please list any diagnostic testing done for this current injury or condition:

_____

Printed Name: _____ Date: _____

Signature: _____ (parent or guardian if under 18)