FULL RANGE PT
& REHAB SERVICES
Your Life. Your Goals. Your Way.

Patient/POA Consent and Financial Responsibility

Full Range Physical Therapy, LLC has been asked by your physician or healthcare provider team to provide physical, occupational, and/or speech therapy evaluation and treatment services. Please read and discuss this document with your therapist, sign and date it to confirm your understanding of, and your agreement to, its content.

I. Informed Consent- My physician has prescribed, and Full Range Physical Therapy, LLC has designed a plan of care to provide physical therapy, speech language pathology, and/or occupational therapy to address one or more of my medical conditions. I agree to receive the services of Full Range Physical Therapy, LLC as recommended in the plan of care designed by my therapist and prescribed by my physician.

II. HIPAA Acknowledgement- I acknowledge receipt of the Notice of Privacy Practices for Full Range Physical Therapy, LLC and had the opportunity to review it with my therapist, prior to signing this document.

III. Statement of Financial Responsibility- I understand that I will be billed for any services provided, and I acknowledge my personal responsibility for that balance, to the extent permitted by law.

Cost of Services

Physical, Occupational, and/or Speech Therapy Evaluation Session:	In Home: $150*	In Clinic: $130*
Physical, Occupational, and/or Speech Therapy Treatment Session:	In Home: $90	In Clinic: $75

* Evaluation pricing waived if patient/client was seen by a Full Range Clinician for skilled services within 2 weeks of start of private pay services.
** Session time may vary depending on treatment provided

If you require additional information or assistance, please contact Full Range Physical Therapy, LLC at 610-241-2685 or visit our website at www.FULLRANGEPT.org

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Services: ☐ **Physical Therapy** ☐ **Speech Therapy**
☐ **Occupational Therapy** ☐ **Other: _____**

Consent: By my signature below I acknowledge that I have read, understand and agree to the terms and conditions contained in the *Informed Consent* and the *Statement of Financial Responsibility* to release all information necessary to secure payment.

Signature: _____ Date: _____

Print: _____

Please check: ☐ **Patient** ☐ **Guardian**
☐ **Financially Responsible Party (Please Specify) _____**