902 Old Quaker Hill Rd.
Pawling, NY 12564
chris@benotafraidpt.com
www.benotafraidpt.com

Client Name: _____ **DOB:** _____
(Please Print)

Welcome and thank you for choosing Be Not Afraid Physical Therapy!

I am honored to accompany you during this time of trial and strive together for you to reach a greater state of health to allow God's natural healing power to actualize in you more and more!

PAYMENT/BILLING POLICIES

Be Not Afraid Physical Therapy PLLC is a fee-for-service clinic. **This means you, the client, are directly responsible to provide payment in full at the time the services are rendered.** Accepted payment methods include cash, check, or credit card/HSA/FSA payment. We will not be submitting anything to your insurance company for reimbursement, though we encourage you to submit for out-of-network benefits if it applies to you.

PRIVACY

I understand that Be Not Afraid Physical Therapy, LLC will maintain my privacy to the highest standards and may use or disclose my personal health information solely for the purposes of carrying out treatment, evaluating the quality of services provided and any administrative operations related to treatment or payment.
Your phone number will be used exclusively to send you messages you have opted to receive based on your consent. We do not sell or share your personal information with third parties.

TREATMENT CONSENT

I understand that I am requesting the services of a licensed physical therapist at Be Not Afraid Physical Therapy, PLLC for evaluation and treatment. Since the physical response to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your response to a certain therapy modality or procedure. We are not able to guarantee precisely what your reaction to a particular treatment might be, nor can we guarantee that our treatment will help the condition you are seeking treatment for. There is also a risk that your treatment may cause pain or injury, or may aggravate previously existing conditions.

You have the right, and are encouraged, to ask your therapist what type of treatment he or she is planning based on your history, diagnosis, symptoms and testing results. You may also discuss with your therapist what the potential risks and benefits of a specific treatment might be. You have the right to decline any portion of your treatment at any time before or during your treatment session.

I have read and fully understand the above statements. I understand the nature and risks of the treatments at Be Not Afraid Physical Therapy, PLLC.

I authorize Christopher Genn, PT, DPT to use treatment techniques as deemed necessary for my safe and effective recovery and optimization of health, and I wish to proceed.

Client Signature: _____ **Date:** _____

Doctor Signature: _____ **Date:** _____

Dr. Christopher Genn PT, DPT