

MEDICALLY INFORMED CONSENT

I voluntarily consent to therapy treatment and services deemed necessary by my therapist and/or physician. I am aware that the practice of physical and occupational therapy is not an exact science and I acknowledge that no guarantees have been made to me as to the results of these services at Prairie Rehabilitation Services, Inc. It is this clinic's sincere intent to educate me on every process, from billing to treatment and eventually discharge from services. Therefore, if techniques that are being used are not understood, it is my responsibility to obtain a clearer understanding of what the therapist's objectives and outcomes are, and how he/she is trying to achieve them.

This consent shall be ongoing for a period not to exceed one year.

I (or _____ for _____) have read this form and fully understand and accept its terms and conditions.

Patient or Person Authorized to consent for Patient/Relationship

Date/Time

Reason patient was unable to consent

Witness Signature

Date/Time

ATTENDANCE EXPECTATIONS

As a patient of Prairie Rehabilitation Services, I agree to attend scheduled therapy appointments and follow the therapist's recommendations and instructions, doing my part to aide in my recovery. I understand if I miss my scheduled appointments, my therapy can be discontinued. If I need to cancel my appointment, I will give 24 hours notice, if possible. I understand that missing my regular scheduled appointment without notice leaves Prairie Rehabilitation Services with an opening in the schedule, which may not be filled.

Patient

Date