Randi Jordan Physical Therapy (RJPT)
Office Policies

This serves to notify clients of my standard office policies. Please sign and date where requested to signify understanding of and agreement with each policy, authorize the release of information and provide consent for treatment.

1. The client is responsible for notifying this office of any address, email or phone number changes.
2. The client is responsible for filling out health and pain questionnaires thoroughly and for updating me at each visit or by email of any changes, such as recent falls, illnesses, surgery, pregnancy or unusual stressors.
3. RJPT accepts cash or check at the time of service. Credit cards may also be used, but incur an additional $5.00 fee.
4. RJPT does not accept any insurance plans, and will not submit records to insurance companies. RJPT provides you with two copies of a master bill for your records and insurance purposes. The evaluation, techniques and treatment plans used in my practice are within the scope of my license, but do not comply with most insurance company guidelines for reimbursement.
5. The office makes reminder calls several days prior to your appointment. Twenty-four hours' notice is required for cancellation. No shows or late cancellations are subject to full fee payment, unless you are sick or in the event of an emergency or hazardous driving conditions.
6. My office is currently accessible only by a steep set of stairs (with two handrails). If, for any reason, you cannot safely use the stairs, please notify the office as soon as possible by phone or email. We will do our best to reschedule your session in another location within easy access of Great Barrington.
7. If you (or your child) are uncomfortable with the treatment for any reason, please communicate that clearly at the time of the session. Pain and discomfort should not result from treatment. If you (or your child) have pain or a reaction after the treatment, please let me know as soon as possible – by phone, text or email – rather than waiting until the next visit.
8. Physical therapy is a collaborative experience. You are encouraged to provide feedback if any aspect of the treatment is not working for you, and I will do my best to find a solution.

9. As part of your treatment, I may provide suggestions – particular foods, supplements, practitioners or books – that may be helpful to you in addressing your condition. I am not a medical doctor, and clients are responsible for checking with their doctor as to the appropriateness of such support.

10. I hereby authorize RJPT to release any information acquired in the course of my examination or treatment, or to discuss my care, with the following practitioners/people for one year after signing.

Name (print)______________ Date__________ Relationship________

Name (print)______________ Date__________ Relationship________

Name (print)______________ Date__________ Relationship________

11. I hereby authorize RJPT to evaluate and administer treatment to me (or my child) that may be deemed necessary or advisable. This authorization is given voluntarily. I acknowledge that no guarantees have been given to me as to the efficacy of the treatments provided at RJPT. Signing this also signifies my understanding of and agreement with the previous ten office policies.

Client signature____

Printed name____

Date____

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