Missed Appointment Policy

We appreciate having you as a patient and are committed to helping you achieve optimal results. Your adherence to the recommended number of treatments is a vital component of your progress in physical therapy.

With the exception of emergencies, it is expected that you keep all of your scheduled appointments. If you are unable to keep a scheduled appointment, please call our office to reschedule. If you need to call after hours, please leave a message on the answering machine. We kindly ask for 24 hours advanced notice. We reserve the right to charge a $25 no-show fee for a missed appointment.

In instances of repeated non-compliance with scheduled appointments, we reserve the right to discontinue care. We will inform your prescribing physician that your physical therapy service has been discontinued due to non-compliance with the prescribed rehabilitation order.

Physical Therapy Treatment Consent

I request and consent to the physical therapy evaluation and treatment performed or directed by a licensed physical therapist at Optimal Sports Physical Therapy. I understand that the physical therapist will evaluate and determine the appropriate treatment and procedures specific to my needs. The treatment will be in compliance with Montana's physical therapy practice at and may include:

Manual therapy techniques, such as spinal and extremity manipulation/mobilization and instrument-assisted techniques (i.e. cupping, ASTYM)
Neuromuscular re-education
Therapeutic activities
Therapeutic exercises
Modalities such as ultrasound, electrical stimulation, iontophoresis, heat/cold therapy

I understand that there are potential risks to treatment while receiving physical therapy. These risks may include, but are not limited to: fractures, disc injuries, cardiovascular issues, pneumothorax, bruising, increase in pain, burns and nerve injury. The therapist may not explain all potential risks at any particular visit, and I have the right to ask questions and terminate any part of the physical therapy treatment at any time.

My signature below acknowledges that I have completely read and understand OSPT's Missed Appointment Policy and Physical Therapy Treatment Consent. I have had the opportunity to inquire about the above information. By signing below, I agree to the aforementioned policies and procedures.

Patient Name: _____

Patient Signature: _____ Date: _____

Below is required if patient is a minor

Name of parent or Legal Guardian: _____

Parent/Legal Guardian Signature: _____ Date: _____