ORTHOPEDIC PHYSICAL THERAPY ASSOCIATES LLC

THRIVE CONSENT AND FINANCIAL AGREEMENT

Patient name _____ Date of birth _____

1) **Consent to Thrive Services:** I authorize Orthopedic Physical Therapy Associates LLC (OPTA) to provide an Initial Assessment and individualized Thrive services focused on fitness, physical performance, healthy aging, and maintaining an active lifestyle. Services may include exercise, movement instruction, balance activities, and education based on my goals and screening findings. I understand that Thrive provides wellness, fitness, performance, and healthy-aging services, rather than medically necessary skilled physical therapy. These services are self-pay, are not billed to insurance, and insurance reimbursement is not expected.

2) **Participation and Changes in My Health:** I understand that physical activity may cause temporary soreness or fatigue and carries a risk of injury. My therapist will explain recommended activities and precautions, and I may ask questions, decline an activity, or stop at any time. I agree to provide accurate health information and promptly report pain, dizziness, new symptoms, or changes in my health. Results are not guaranteed. If my symptoms or screening findings suggest a need for skilled physical therapy or other medical evaluation, my therapist will discuss appropriate next steps with me.

3) **Financial Responsibility:** Thrive is a self-pay service. I am responsible for the charges for services I receive. The Initial Assessment is $150 for a 45-minute, one-on-one appointment. Follow-up visits are $80 for 30 minutes. Payment is due in full at the time of service. Accepted payment methods include cash, check, debit card, and credit card. Any additional services or changes to my fees will be discussed with me before I receive those services.

4) **Attendance and Cancellations:** Consistent attendance supports progress toward my goals. OPTA requests at least 24 hours' notice for appointment cancellations. A $50 cancellation or no-show fee may be charged for a cancellation with less than 24 hours' notice or a missed appointment without notice.

5) **Respectful Care:** OPTA provides services without discrimination based on race, color, national origin, religion, sex, disability, or age.

6) **Privacy Acknowledgment:** I acknowledge that I have received OPTA's Notice of Privacy Practices.

I have read this agreement, had an opportunity to ask questions, and agree to its terms.

_____ _____

Patient or Responsible Party Signature Date

_____ _____

Witness Date