



Dear Patient,

Welcome to our clinic. We are pleased that you have chosen us for your rehabilitation needs. Our goal is to provide you with the highest quality care in a clean and professional environment. Before you begin your therapy program, an evaluation will be performed to assess your individual needs. The evaluation will take approximately 60 minutes. It is important that you come to your evaluation at least 15 minutes early to complete necessary paperwork.

When you come for your evaluation, you should bring the following information:

1. Therapy prescription from physician
2. Insurance card
3. Co-pay (if applicable)
4. List of medications you are currently taking

Appointments:

Patients are seen by appointment only. After your evaluation, schedule follow up visits at our reception desk. It is critical that you are on time for your appointments. Being late may make it necessary to shorten your therapy session so it does not disrupt other patient's scheduled appointments.

Appropriate Attire:

Please wear clothes suitable and comfortable to perform exercise. This includes shorts, sweats, athletic sweats and shirt. If you have a knee problem it is best to wear shorts so we can work on your knee, as needed.

**Attendance Policy:** It is very important that you attend all of your scheduled visits. If you cannot attend, we require that you call **at least 24 hours in advance** so that we can fill your scheduled slot with another patient.

Inconsistent attendance: If you do not show for your regular appointments, or are inconsistent in attending therapy, you may be discharged from therapy. Your physician and/or case manager will be notified and you will not be able to return to therapy without a new doctor's order.

Regular attendance and active participation in your therapy program is necessary for you to get the maximum benefit from our services. It is also important for you to have open communication with your therapist about the therapy being provided and any pain you might be experiencing so that therapy can be adjusted to meet your needs.

Complaints or Recommendations: We encourage open communication. If you have any complaints, concerns or recommendations, please ask to speak with the front desk staff.

If you have any questions regarding our services, please call our office at 508-824-1000.

We look forward to working with you.

Sincerely,

Robert Perednia, DPT  
Director of Physical Therapy

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**Joint Effort Physical Therapy is owned by Saperia Orthopaedics & Sports Medicine.**

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# Joint Effort Physical Therapy

What brings you in for physical therapy today?

Location of pain or injury \_\_\_\_\_

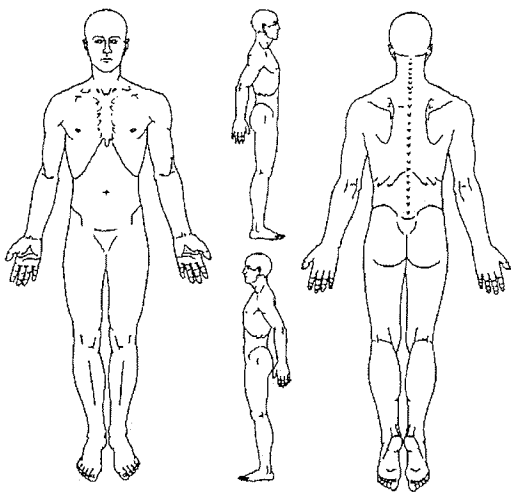
Cause of pain or injury \_\_\_\_\_

Date injured or noticed the pain \_\_\_\_\_

Your primary care physician \_\_\_\_\_

Are you allergic to latex? Yes \_\_\_\_\_ No \_\_\_\_\_ Do you have any other allergies? \_\_\_\_\_

Have you had any physical therapy this calendar year? Yes \_\_\_\_\_ No \_\_\_\_\_

	<p>If you are experiencing pain, please indicate the location of the pain on the body diagram with an "X"</p> <p>If you are experiencing numbness, please indicate the location of the numbness on the body diagram with an "O"</p>
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I hereby authorize the therapists at Joint Effort Physical Therapy to perform the treatments or procedures approved by my referring physician. I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and/or procedures. I fully understand that it is impossible to make any guarantees regarding the outcome of any medical treatment or procedure. I give my permission to release any medical records to my insurance carrier(s) to secure payment for physical therapy services rendered. I acknowledge receipt of Joint Effort Physical Therapy Notice of Privacy Policy. I acknowledge that I have reviewed the attendance policy.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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## Joint Effort Physical Therapy

### CANCELLATION AND NO SHOW POLICY FOR APPOINTMENTS

Our goal is to provide quality care in a timely manner. In order to do so we are implementing a formal cancellation/no-show policy.

In order to be respectful of the medical needs of others, please be courteous and call 508-824-1000 at least 24 hours prior to your appointment time if you are unable to attend. If you cannot reach someone, please leave a detailed message on the voicemail.

Late cancellations and/or no-show appointments will be susceptible to a \$20.00 charge.

After your second no-show appointment or third cancellation, you may be released/discharged at the therapist's discretion and a note will be written to the referring physician.

Thank you for your cooperation.

\_\_\_\_\_  
Patient's signature

\_\_\_\_\_  
Date