Injury Quick Screen - Phone Consultation

Consent & Financial Agreement

Patient / Athlete: _____ Date of Birth: _____

Parent / Legal Guardian (if minor): _____ Patient location (state) at time of call: _____

Phone: _____ Email: _____

1. Purpose and limitations

I request a scheduled telephone injury screening with Dr. Ezara Greene, PT, DPT, SCS. The clinician may obtain a brief injury history, discuss reported symptoms, and recommend the appropriate next level of care, including emergency services, another healthcare provider, or a formal physical therapy injury evaluation. This is a limited triage service, not a comprehensive PT evaluation, diagnosis, medical clearance, individualized treatment plan, or treatment session. Specific interventions cannot be determined by phone alone. A formal in-person assessment may be recommended. In an emergency, call 911.

2. Telephone consultation and authorization

I consent to the telephone consultation and understand the limitations of remote communication, including no hands-on examination and possible technical or privacy risks. I will provide accurate information and disclose the patient's physical location. The call may proceed only where Dr. Greene is authorized to provide the service. A parent or legal guardian must consent for a minor.

3. Fees and payment

Select the booked consultation duration (prices include Square processing fees):

☐ 15 min - $73.55 ☐ 30 min - $102.96 ☐ 45 min - $137.05

Full payment is due before the appointment, and a valid credit card must remain on file. Additional consultation time requires prior approval and may incur a disclosed charge. Weekend, holiday, or specially arranged urgent calls may have disclosed premium rates.

4. Required paperwork

Signed consent and required payment information must be received at least 24 hours before the call. If consent, payment, or a valid card is missing, the appointment may be canceled.

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Consent & Financial Agreement (continued)

5. Cancellation and no-show policy

At least 24 hours' notice is required to cancel or reschedule. Cancellation with less than 24 hours' notice incurs a separate $62.22 late-cancellation fee charged to the card on file. No-shows and unanswered calls are nonrefundable: the prepaid consultation fee is forfeited PLUS a separate $62.22 no-show fee. No complimentary rescheduling or appointment credit is provided for a no-show.

6. Insurance and billing

Perfect 10.0 Physical Therapy is a cash-based, fee-for-service practice and does not bill insurance. No insurance claims or superbills are provided for this service. The practice states this service is not covered under its applicable Medicare, Medicaid, or TRICARE arrangements. I understand I am responsible for the stated charges.

7. Acknowledgment and payment authorization

By signing, I confirm that I understand the limited scope, telephone limitations, fees, 24-hour deadlines, and no-show charges. I authorize charges to the payment card provided in the separate Credit Card Authorization form for the booked consultation, approved additional time, and applicable late-cancellation or no-show fees. No outcome is guaranteed.

Patient / Parent / Guardian Signature: _____ Date: _____

Printed Name / Relationship (if guardian): _____

Perfect 10.0 Physical Therapy, PLLC
Phone: 571-252-9131 | Email: admin@perfect10pt.org
Fax: 571-410-2230 | Website: www.perfect10pt.org

Credit Card Authorization

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By providing the credit card information below, I authorize Perfect 10.0 Physical Therapy, PLLC to charge this card for the booked phone consultation and applicable additional time, late-cancellation, or no-show fees as described in the separate Consent & Financial Agreement. I understand that I may withdraw authorization for subsequent charges at any time in writing.

_____ *(Initial here) I have read and agree to the payment authorization above.*

_____ *(Initial here) I authorize charges to the card listed below.*

Card Type:

☐ Visa ☐ AMEX

☐ MasterCard ☐ Discover

Name on Credit Card: _____

Credit Card Number: _____

Expiration Date: _____

CVV # (on the back of the card): _____

Billing Address: _____

Signature of Financially Responsible Party: _____ Date: _____

Printed Name of Financially Responsible Party: _____

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