IPA PHYSIO DALLAS
469.782.9978
DALLAS@IPA.PHYSIO
WWW.IPA.PHYSIO

DIRECT ACCESS TO PHYSICAL THERAPY SERVICES

You are receiving direct access to physical therapy services from an individual who is a physical therapist licensed by the Texas Board of Physical Therapy Examiners and has met all of the board's requirements. Under Texas law, you may continue to receive physical therapy treatment services for a period of up to 10 consecutive business days. If you need treatment beyond the initial 2 week period, your physician must sign, date, and return the plan of care developed by your physical therapist.

We will assist you with getting your plan of care to your healthcare provider of choice that meets the state qualifications. Ultimately, it is your responsibility to get the plan of care signed, dated, and returned to your physical therapist in a timely manner so there is no delay in your care.

PLEASE READ CAREFULLY AND ACKNOWLEDGE BELOW:

- I understand that physical therapy treatment without a referral will be based on the physical therapist's examination and evaluation of my current condition which may result in identification of movement and mobility dysfunction.
- I understand that the physical therapist will not diagnose an illness or disease, and that physical therapy is not a substitute for a medical diagnosis.
- I understand that if a medical diagnosis has already been established by a qualified healthcare practitioner, the physical therapist will take it into consideration during the evaluation process.
- I understand that the physical therapy plan of care developed by the physical therapist may not be based on radiological imaging.
- I understand that if images have previously been obtained, the physical therapist may use the information as part of the evaluation process.
- I understand that if the physical therapist identifies a need for radiological imaging, the physical therapist may recommend that radiological imaging be obtained.
- I understand that my health insurance may not cover physical therapy services if provided without a referral from a qualified healthcare practitioner. (IPA Physio will assist you with verifying the requirements for your insurance plan)

I ACKNOWLEDGE THAT I HAVE RECEIVED THE ABOVE DISCLOSURE.

Patient's Name (*please print*): _____

_____ _____

Signature (*Patient or Legal Representative**) Date

*If signed by a Legal Representative, please print *Name* and *Relationship to Patient*

Please let us know if you have any other questions or concerns.

ADVANCED PHYSICAL THERAPY

Prescription required by: ____/____/____