WILSON WELLNESS, LLC
LAURA SIMMONS, PT, LLC ~ FISHER FITNESS, LLC
1230 FALL CREEK ROAD~ PO BOX 1482~ WILSON, WY 83014
307-690-5558 ~ FAX: 307-201-1815

CONSENT FORM

I. Physical Therapy examination and therapeutic procedures including manual therapy techniques, therapeutic exercise, education, functional movement training, thermal and physical modalities and Personal Training, well guided, are considered safe and effective methods of care.
Any procedure intended to help may create temporary worsening of symptoms or new areas of discomfort as your body self-adjusts to the new information it has received and processes changes. While the chance of experiencing adverse effects from treatment is small, we wish to inform all patients of the potential side effects of treatment.

Please read and initial the following:

a. ___I hereby acknowledge Wilson Wellness therapists to provide me with physical therapy, bodywork, physical training and/or wellness services.
b. ___I understand and agree that regardless of insurance coverage, I will pay the full balance of my bill incurred for services rendered on the day I receive such services, or by prepayment arrangement.
c. ___If I have to cancel or miss a scheduled appointment, I agree to give 24 hours notice or pay for the appointment time in full.

II. I have read and understand the above statements regarding treatment side effects and consent for treatment. I understand that there is no guarantee or warranty for a specific treatment result, and that my participation in treatment recommendations is key to a positive outcome.
I also acknowledge understanding of and agree to the billing practice of this clinic.

Signature: Date: