Informed Consent and Payment Agreement for Treatment
Stay Strong Therapies, LLC

Victoria Magnan, OTR, CKTP, CLT-LANA is the founder and sole treatment provider for Stay Strong Therapies. She is licensed with the State of Wisconsin as an Occupational Therapist (license 2435-26). She has extensive experience providing lymphedema treatment, compression fitting, kinesiology taping, lymphatic and vascular exercise programs and education. Healthcare assessment is limited to the specialties described. This treatment does not represent a comprehensive health assessment. This is a form of occupational therapy and lymphedema services. _____

As the sole treatment provider of Stay Strong Therapies, treatment planning and consultation does not involve other healthcare providers in this office. Your record remains confidential unless you have agreed to release information to providers outside of the office. _____

Treatment is a collaborative process, and your questions and feedback are welcomed! You have the right to have all aspects of treatment explained to you and decline any aspects of treatment. Treatments may have alternatives and do not offer guarantees. Following your initial consultation, a treatment plan will be provided along with the proposed costs of each session. The initial consultation fee: $135-$225 based on the length of your appointment time. _____

Payment for treatment is the sole responsibility of the patient. Stay Strong Therapies does not bill insurance or communicate with outside agencies for the purpose of payment or treatment monitoring. Costs are explained to you in advance of treatment. Payment is due at the time of service. Payment can be made using credit card, check, or cash. Non-payment is not an option; Stay Strong Therapies does not carry balances. _____

Fees for no-show and cancellation less than 24-hour notice are based on the length of treatment reserved. A minimum of $50 will be charged. _____

By initialing the above policies and signing below, I certify that I have read them, understand them, and will comply.

_____ _____

Signature of Patient or Guardian **Date**