YOUR
LOGO

**COMPANY NAME**

PHYSIOTHERAPY SERVICES PROPOSAL

Prepared by:

**[Client Name]**

**[Contact information]**

**[Date]**

# Introduction

Thank you for considering [Your Clinic or Practice Name] to support your physical health and rehabilitation needs. We provide evidence-based physiotherapy services tailored to individuals and organizations seeking pain relief, mobility improvement, and functional recovery.

# Client Goals

[Client Name] is seeking physiotherapy support to address [specific concerns such as injury recovery, chronic pain, post-operative rehab, mobility, etc.].

# Proposed Services

We propose a personalized physiotherapy treatment plan that includes:

- Comprehensive physical assessment
- Individualized treatment sessions
- Exercise prescription and monitoring
- Education on posture, ergonomics, and injury prevention

# Scope of Work

Our physiotherapy services include:

- In-clinic or on-site physical therapy
- Manual therapy, dry needling, taping (as appropriate)
- Strengthening and mobility programs
- Postural training and ergonomic consulting
- Documentation and progress reviews

# Timeline

Estimated phases of care and recovery milestones:

|  |  |  |
| --- | --- | --- |
| Phase | Description | Estimated Date |
| Initial Assessment | Evaluate condition and build plan | [Start Date] |
| Treatment Phase | Weekly or bi-weekly therapy sessions | [Ongoing] |
| Midpoint Review | Progress check and program adjustment | [Midpoint] |
| Final Evaluation | Outcome measurement and discharge plan | [Completion Date] |

# Pricing

Estimated costs for physiotherapy services:

|  |  |  |
| --- | --- | --- |
| Service | Description | Cost |
| Initial Consultation | Assessment and treatment planning | [Amount] |
| Standard Session | 45–60 minute therapy session | [Amount] |
| Corporate Plan | On-site or group sessions | [Amount] |
| Total (Est.) |  | [Total] |

# About Us

[Your Clinic Name] has served patients for over [X] years with a team of licensed physiotherapists and rehabilitation professionals.

- Expertise: Orthopedic, neurological, sports and geriatric therapy
- Certifications: Registered with [relevant board or licensing body]
- Mission: To restore mobility and quality of life with compassionate care

# Case Studies / Testimonials

Case Study: [Patient Name / Employer]

- Condition: ACL reconstruction rehab
- Outcome: Full return to sport in 4 months with measurable strength gains

Testimonial:
“[Your Clinic] made a huge difference in my recovery. I felt supported and empowered every step of the way.” — [Client Name]

# Terms and Conditions

Payment Terms: Payment due per session or monthly invoicing for corporate plans.
Cancellation Policy: 24-hour notice required for cancellations.
Confidentiality: All medical and personal information is kept strictly confidential.
Referrals: Medical referral not required unless requested by insurer or physician.

# Acceptance

To begin physiotherapy services, please sign below.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Name: [Client’s Printed Name]
Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_