PERFORMANCE PHYSICAL THERAPY & SPORTSLAB

PATIENT CONSENT

CONSENT FOR TREATMENT: I VOLUNTARILY CONSENT TO THE RENDERING OF CARE PROVIDED TO ME BY **PERFORMANCE PHYSICAL THERAPY & SPORTSLAB.** I UNDERSTAND THAT I AM UNDER THE CARE OF A LICENSED PHYSICAL THERAPIST.

RELEASE OF INFORMATION: BY SIGNING THIS FORM, YOU ARE GRANTING CONSENT TO **PERFORMANCE PHYSICAL THERAPY & SPORTSLAB** TO USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS AS OUTLINED IN OUR NOTICE OF PRIVACY PRACTICES PROVIDED FOR YOUR REVIEW. YOU HAVE A LEGAL RIGHT TO REVIEW OUR NOTICE OF PRIVACY PRACTICES BEFORE YOU SIGN THIS CONSENT, AND WE ENCOURAGE YOU TO READ IT IN FULL.

MEDICARE AND MEDICAID CONSENT TO RELEASE INFORMATION: I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER TITLE XVIII AND/OR TITLE XI OF THE SOCIAL SECURITY ACT IS CORRECT. I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION OR ITS INTERMEDIARY CARRIERS ANY INFORMATION NEEDED FOR THIS OR RELATED MEDICARE OR MEDICAID CLAIM.

INFORMED CONSENT TO PARTICIPATE IN ACTIVE REHABILITATION: THE GOALS OF YOUR REHABILITATION ARE AS FOLLOWS:

1. DETERMINE THE EXTENT OF YOUR PROBLEM
2. PROVIDE A THERAPEUTIC EXERCISE PROGRAM TO REDUCE YOUR PAIN AND INCREASE YOUR FUNCTION
3. RETURN YOU TO FULL-DUTY, NON-RESTRICTED WORK STATUS AND LIFESTYLE

YOUR PARTICIPATION IN THE REHABILITATION PROGRAM IS VOLUNTARY. YOU CAN STOP AT ANY POINT IN THE PROGRAM. IF YOU CHOOSE TO STOP YOUR PROGRAM, WE ARE OBLIGATED TO NOTIFY YOUR DOCTOR, INSURANCE COMPANY, ATTORNEY, AND/OR CASE MANAGER WHERE IT IS APPLICABLE.

IF AT ANY POINT DURING THE EVALUATION OR REHABILITATION PROCESS YOU HAVE ANY QUESTIONS, WE WILL ANSWER THEM TO THE BEST OF OUR ABILITY OR REFER YOU TO SOMEONE MORE QUALIFIED.

THERE ARE NO GUARANTEES THAT YOUR PERSONAL GOALS AND/OR THOSE LISTED ABOVE WILL BE MET TO YOUR SATISFACTION. THE SUCCESS OF ANY REHABILITATION PROCESS LIES IN THE COMBINED EFFORTS OF YOU AND YOUR PROVIDERS.

IN ORDER TO MEET THE FIRST GOAL LISTED ABOVE, THE PHYSICAL THERAPIST NEEDS TO DO A THOROUGH INITIAL EVALUATION OF WHAT MOVEMENTS AND ACTIVITIES CAUSE YOUR PAIN IN ORDER TO BEST TAILOR YOUR TREATMENT PROGRAM. DUE TO THIS, THERE IS A CHANCE OF AGGRAVATION OF YOUR CONDITION OR INJURY AFTER THE FIRST VISIT WITH US. **YOU MAY EXPERIENCE INCREASED PAIN AND DISCOMFORT AFTER YOUR FIRST VISIT WITH US.** PLEASE COMMUNICATE TO YOUR PHYSICAL THERAPIST ANY AGGRAVATION OF YOUR CONDITION OR INJURY THAT YOU EXPERIENCE DURING THE REHABILITATION PROCESS.

I UNDERSTAND THAT MY PROGRESS AND RECOVERY ALSO RELIES ON THE CONTINUATION OF MY THERAPY THROUGH MY INDIVIDUAL HOME EXERCISE PROGRAM GIVEN AND EXPLAINED TO ME BY **PERFORMANCE PHYSICAL THERAPY & SPORTSLAB.**

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE READ OR HAD THIS FORM READ AND/OR EXPLAINED TO ME. I FULLY UNDERSTAND ITS CONTENTS AND HAVE BEEN GIVEN AMPLE OPPORTUNITY TO ASK QUESTIONS REGARDING ITS CONTENT. I HEREBY VOLUNTARILY CONSENT TO UNDERGO TREATMENT AND PROCEDURES THAT WILL BE ADVISED BY THE PHYSICAL THERAPIST AT THIS FACILITY.

PRINTED NAME OF PATIENT____

SIGNATURE OF PATIENT______________________________ DATE________________