**Treatment Consent**

I hereby give my voluntary consent to be evaluated and treated at Optimal Form & Function, LLC for the purpose of addressing the signs and symptoms that I am currently experiencing that are deemed necessary by my physical therapist and/or physician.

I have the right to discuss the potential risks and benefits involved in in my treatment beforehand to my satisfaction. I understand and I am informed that, as in the practice of medicine, physical therapy may have some risks. I understand that I have the right to ask about these risks and have any questions about my conditions answered prior to treatment.

I have been informed of the nature of my disorder(s) and of the nature and purpose of physical therapy and related therapeutic procedures for treatment. I acknowledge that no guarantees have been made to me as to the results of services at Optimal Form & Function, LLC.

I have read this consent form and understand the risks involved in physical therapy. I hereby consent to evaluation and/or treatment of my condition by licensed physical therapist employed by Optimal Form & Function, LLC.

Initials:\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_

**Medical Disclosure**

I acknowledge that it is up to me to inform my provider of physical therapy about any health problems or allergies I have, medication I am taking, as well as any changed to my medical history/status as they arise.

Initials:\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_

**Waiver and Release**

In the event that I get ill or injured, I hereby grant permission to the employee(s) at Optimal Form & Function, LLC to obtain emergency care or medical attention that is deemed medically necessary. I give my full consent to Optimal Form & Function, LLC to execute the consent required to fulfill all necessary emergency care and medical attention. I declare that Optimal Form & Function, LLC be released, discharged and acquitted from any liability, and I agree to indemnify them against any claim, demand, damage, or loss of any kind arising out of my refusal to accept, allow, or receive emergency and/or medical services. Initials:\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_

**Liability**

I acknowledge that Optimal Form & Function Physical Therapy, LLC is not responsible for any lost or damaged personal belongings that are left unattended.

Initials:\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_

**Financial Responsibility**

I acknowledge that payment is due at the time of treatment. I agree to pay Optimal Form & Function, LLC all amounts that are due for services. Optimal Form & Function, LLC will provide a superbill for you to submit to your insurance company within 24 hours of your visit.

Initials:\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_

I agree to keep a current credit, HSA, or FSA card on file with Optimal Form & Function, LLC. By providing your credit care information below, you have authorized us to charge unpaid balances and fees of any kind to this card.

Initials:\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_

I do not agree to keep a current credit, HSA, or FSA card on file with Optimal Form & Function, LLC.

Initials:\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_

If you do not provide a valid payment method, any unpaid balances will be sent to collections.

By my signing below, I attest that I have read carefully and fully understand all items and accept the terms and conditions in each item.

Signature of Patient or Legal Guardian:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_

Patient Name (Printed):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_