New Patient Information

Consent to Therapy

I have presented myself to this facility for therapy treatments and consent to diagnostic procedures by my attending therapist.

I realize I have the right to refuse any drugs, treatments or procedures to the extent permitted by law. I acknowledge that medicine is not an exact science, no guarantees or warranties can be made to me regarding the results of any treatments at this facility. I understand that information from any medical record(s) kept by this facility may be used for educational, administrative, and/or facility approved purposes when my personal identity will not be revealed.

Authorization for Release of Information

I, _____give Dynamic Physical Therapy consent for the release of my records to any authorized representative(s) of Medicare, Medicare Intermediary, Worker's Compensation, Private Insurance Company and/or Consulting Physician(s) for review in determining benefits to which I am entitled. I further authorize the facility to review my records and/or make photocopies of said records. I fully understand that I can, by legal right, refuse the release of said records. Therefore, I hereby authorize the facility access to my records.

I consent to maintain the confidentiality of other patients of the facility, to not disclose to anyone the identity of anyone or anything discussed at the facility by anyone other than myself.

This facility takes photographs of patients while performing therapy to be displayed in your chart.
Do you consent to have your photograph taken? ____YES ____No

I HAVE READ AND FULLY UNDERSTAND THE ABOVE GENERAL CONSENT FORM AND ANY QUESTION(S) I MAY HAVE HAD, HAS BEEN ANSWERED TO MY SATISFACTION.

_____

Signature of Patient (or Guardian if Patient is a Minor – Under 18) Date:

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Witness (Authorized Signature of Dynamic Physical Therapy) Date: