

Consent Forms

Consent to Examination and Treatment

Informed Consent

I hereby consent to a physical therapy examination and subsequent treatment as recommended by the examining physical therapist with Thrive Physical Therapy.

Examination: I understand the examination includes providing a medical, social and physical activity history and reporting of my symptoms and complaints. I agree to allow the physical therapist to perform all physical tests and measures required to identify my physical therapy diagnosis, problems and prognosis. I understand that some tests and measures may require the physical therapist to perform a visual inspection of exposed body areas or palpate body parts that are sensitive or painful. I also understand that there are some risks in participating in a physical examination, including but not limited to developing soreness, increased pain, new pain in different areas, an aggravation of existing symptoms or a new injury. I understand that if I am uncomfortable at any time during the examination, I can let the therapist know and may refuse to continue the examination at my choice. If I refuse to participate in any part of the examination, I understand that the physical therapist may not be able to provide an accurate physical therapy diagnosis/prognosis or develop the most appropriate treatment plan.

Treatment: I acknowledge that my physical therapist (hereinafter "PT") has informed me of my diagnosis, prognosis and the potential risks and benefits of all recommended interventions in my proposed plan of care and I have been given an opportunity to have all my questions answered. I hereby agree to participate in and consent to receive the physical therapy interventions recommended by my PT as outlined in my treatment plan. I understand that the response to different physical therapy interventions varies from person to person and sometimes treatment interventions may result in increased pain, an aggravation of existing symptoms or a new injury. Therefore, I agree to inform my PT of any change in my symptoms and function so my treatment plan can be adjusted accordingly. I understand that I may decline any intervention at any time by informing my PT of my desires/concerns and that my refusal may result in a termination of my treatment if my PT determines that there are no other treatment alternatives or the refused intervention is essential to meeting my goals. I also understand that although we have set rehabilitation goals, my PT has made no guarantees that any particular outcomes will result from the therapy interventions.

Acknowledgement

I have read and understand the benefits and risks involved in participating in a physical therapy examination and treatment. I consent to the examination and treatment, accept any and all associated risks involved and agree to fully cooperate and participate in the proposed physical therapy interventions in the established plan of care.

Consent to Electronic Communication

Informed Consent

We respect the privacy rights of all our patients and will therefore only communicate with patients and parents/guardians through email, text or voice mail messaging with your written consent. Email can be inherently insecure if your email service does not use encryption. Also, if your email address is through your employer, your

employer may have access to your email box. Voice mail may also be insecure, especially if you use a VOIP phone service. When you consent to communicating with us by email, text or phone, you are agreeing to accept the risk that your protected health information may be intercepted by persons not authorized to receive such information. Since we do not control the email and phone systems you use, we are not responsible for any privacy or security breaches that may occur through voicemail, email or text communications that you have consented to.

You may choose to limit the type of voicemail, email or text communication you have with us if you wish to limit your risk of exposing your protected health information to unauthorized persons. Please indicate below what types of correspondence you consent to receive by email, text, and/or voicemail.

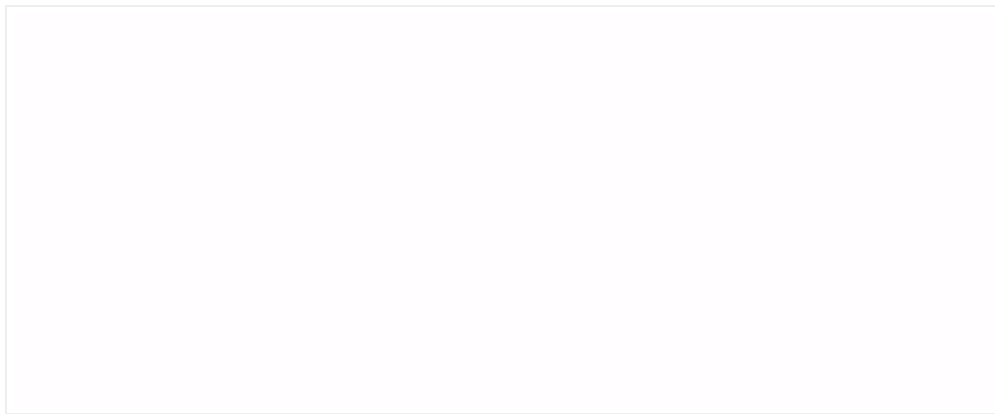
Please indicate below what types of correspondence you consent to receive by email, text, and/or voicemail.

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| <input type="checkbox"/> I consent to all communication, including but not limited to communication about my medical condition and advice from my health care providers | <input type="checkbox"/> I consent to receiving communication about the scheduling of appointments (limiting the information disclosed) | <input type="checkbox"/> I do not consent to any voicemail, email or texting communication. |
|---|---|---|

Signature

If in agreement with the terms above, please sign below:

Please use your mouse or finger to draw your signature below



Date: