



WELCOME TO SPOONER PHYSICAL THERAPY

We are pleased that you have chosen **Spooner Physical Therapy** to be a part of your rehabilitation experience. We find that regular communication assists in providing the best service to you. Please carefully read each section below, sign and date, and return to the front office personnel.

AUTHORIZATION FOR TREATMENT

All procedures will be thoroughly explained to you before they are performed.

There are certain inherent risks with Physical/Occupational Therapy treatment because you will be asked to exert effort and perform activities with increasing degrees of difficulty, which could cause an increase in your current level of pain or discomfort or an aggravation to your existing injury. There is also a possibility that you could experience a new injury, but this risk is small. You will be able to control any procedure by stopping if you feel any increase in pain or discomfort.

The Physical/Occupational Therapist and/or Physical/Occupational Therapist's Assistant will take every precaution to ensure that you are protected from any hazardous situation. You will never be forced to perform any procedure that you do not wish to perform.

Based on the above information I agree to cooperate fully and to participate in all Physical/Occupational Therapy procedures and to comply with the plan of care as it is established.

NOTICE TO PATIENTS: For personal safety, do not use any equipment without a staff member present.

Initial _____

NOTICE OF INFORMATION PRACTICES

I have read and fully understand Spooner Physical Therapy's **Notice of Information Practices**. I understand that Spooner Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Spooner Physical Therapy will consider the requests for restrictions on a case by case basis, but does not have to agree to requests for restrictions.

I authorize the use and disclosure of my personal health information for purposes as noted in Spooner Physical Therapy's **Notice of Information Practices**. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Initial _____

DESIGNATED INDIVIDUALS AUTHORIZATION

I authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Name _____ Relationship _____

Name _____ Relationship _____

PATIENT INFORMATION CONSENT

I authorize Spooner Physical Therapy to use my protected health information for targeted marketing, fundraising and/or solicitation of participation in research studies. I understand that I have the right to copy or inspect any information used for these purposes. I also understand that this authorization does not affect my consent to use my protected health information for treatment, billing or operations related to treatment and billing.

Initial _____ (optional)

I have read and understand the above information.

Patient Name _____

Patient Signature _____ **Date** _____

Legal Guardian Signature _____ **Date** _____