Authorization for Care and Informed Consent

I hereby authorize to receive care at Reclaim Physical Therapy. I understand that receiving physical therapy may involve stress of musculoskeletal tissue that may cause soreness. Additional risks include, but are not limited to cardiovascular, muscle, ligament, joint, or disc injury. Symptomatic aggravation of your current condition is possible. Furthermore, I understand that the provider may need to perform mobilization technique, manipulation technique, massage technique, manual traction, distraction, and other modalities and services that may produce brief (several days) soreness and discomfort. It is my/our responsibility to communicate any difficulties that I/we are having during treatment or any medical or activity changes to my/our provider. Please acknowledge consent with full knowledge of the nature and risks of the evaluation and treatment program with your initials.

(Initial) __________

Release of Protected Health Information

I, ________________________, understand that in compliance with the Health Insurance Portability and accountability Act (HIPAA), Reclaim Physical Therapy will not disclose your protected health information (PHI) without your explicit authorization, except as permitted by law for the purpose of payment, treatment, and healthcare operations.

If you chose to have your PHI communicated to individuals other than yourself, please complete the information below, and sign the authorization. Additionally, please recognize that you are responsible to notify Reclaim Physical Therapy if there are any changes to the below listed individuals privy to your PHI.

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

Patient Name:____

Patient/Guardian Signature:____________________________________ **Date:**___________