Bumps and Bruises Consent

Patient Name_____ **Date**_____
Patient DOB_____ **Sport/Team**_____

Consent of treatment: On behalf of the patient, consent is hereby given to **Delta/Fillmore Physical Therapy**, medical staff and employees to provide health care services to the patient and to administer physical therapy for the benefit of the patient for this visit and any subsequent visits, and it is understood that this consent may be revoked in writing at any time. It is understood that there is a risk of substantial and serious harm involved in such health care services, and such risk is accepted in the hope of obtaining beneficial serious harm involved in such health care services, and such risk is accepted in the hope to obtain beneficial results from such service. No promises of any particular outcome or successful result have been made, it being understood and accepted that there are some uncertain cases, to obtain separate consent for some of the services that they perform.

Release of information: The law requires health care providers to make and keep records of your treatment. These records are safeguarded by the facility. Access to medical records is limited to persons who are providing, coordinating, evaluating or improving health care, subject to applicable law. By receiving services at this facility you agree to the release of medical record information for the uses specified above. **YOU ALSO AGREE TO THE RELEASE OF INFORMATION TO YOUR REFERRING COACH IN ORDER TO COORDINATE YOUR SAFE RETURN TO PARTICIPATION IN YOUR SPORT. NOTIFY THE FRONT DESK IF YOU DO NOT WANT THIS COORDINATION.**

Our clinic will occasionally use photographic documentation to track progress and status. This documentation will be placed in your electronic file and used for billing and may be released to the physician if requested. By signing below, you acknowledge and consent to this type of documentation

Parent name (please print)_____ **Phone number**_____

Parent signature_____ **Date**_____