Consent, Disclosure & Privacy

I hear by give my consent to Athletic Advantage Physical Therapy to provide the desired services be it physical therapy, wellness, physical training, exercise prescription or massage, as requested by myself, or my family member(s).

I understand that Athletic Advantage Physical Therapy is fully licensed and its providing therapists are highly trained and skilled. They (AAPT Therapist) will ensure that the service they provide is safe, appropriate, and indicated for my condition.

While Athletic Advantage Physical Therapy fully intends to give service that offers no harm, I understand that there is ALWAYS THE POTENTIAL FOR AN UNFORESEEN ACCIDENT TO OCCUR. I understand and am informed that, as with all forms of medical treatments, physical therapy may have potential risks and benefits associated with my condition(s). Should an unforeseen accident be the case, I recognize that Athletic Advantage Physical Therapy has taken every necessary precaution to protect me, and therefore, I DO NOT HOLD Athletic Advantage Physical Therapy liable for any unforeseen injury.

The physical therapist will explain the benefits, side effects, and potential complications regarding each chosen treatment; I understand that I have the right to ask about these risks and about my condition prior to treatment. I, or my family, have provided full disclosure of any and all relevant past medical history that may impact, influence or contraindicate the prescribed service provided by Athletic Advantage Physical Therapy. I have the right to decline any portion of the treatment at any time before or during the treatment session.

I understand that Athletic Advantage Physical Therapy is a private pay company, and not contracted with any insurance companies, including Medicare. Athletic Advantage Physical Therapy will not submit insurance claims for me. However, I understand that it is my right to submit invoices provided to me upon request to my insurance company. I also understand that it is my responsibility to know my insurance policy and their requirements for reimbursement. I understand that reimbursement from my insurance is not guaranteed.

Athletic Advantage Physical Therapy ensures that information about me and my condition, or reason for receiving services, will remain private and be fully disclosed only upon my written approval.

Client Name	Client Signature	Date
Parent/Guardian Name (if under 18)	Parent/Guardian Signature	Date