#

# A close up of a logo  Description automatically generated

# Per4orm Recovery Consent & Waiver

I hereby agree that by signing this document, I consent to waive certain legal rights, including the right to sue the following party, and if applicable, its owners, therapists, representatives, and facilities from any physical, mental, tangible or intangible loss or damage that may occur to me during my participation in any services provided.

Jonathan Casero, MS, ATC, LAT

DOC

Detailed Orthopedic Care

Per4orm Rx

10380 W State Rd 84 #14

Davie, FL 33324

JDCasero@gmail.com

I am voluntarily receiving recovery services from the ATC listed above.

Date: \_\_\_\_\_\_\_\_\_\_\_

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Guardian’s Name (If applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Guardian Signature (If applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_