

SYNAPSE HOUSE
CONSENT & ACKNOWLEDGEMENTS – 2.01.C

Synapse House and State and Federal Law requires this form be completed in its entirety.

Consent to Treatment

I, and/or my legal guardian hereby authorize Synapse House to perform such services as prescribed by the person's served treatment plan or as required from time to time in the exercise of good therapeutic judgment, subject to any rights provided to the person served by Federal or State law.

YES **NO**

Consent to Virtual Treatment

I, and/or my legal guardian hereby agree to receive services virtually. I understand that virtual or telehealth services use a high quality, real-time audiovisual link using a HIPAA compliant platform. I understand that telehealth may involve electronic communication of my personal medical information to other healthcare practitioners who may be located, in other areas, including out of state. I further understand that all privacy and confidentiality practices of Synapse House apply to virtual services.

YES **NO**

Use of Image and Personal Story

I, and/or my legal guardian hereby authorize Synapse House to use photographs, audio, video and my personal story for marketing purposes, education or to increase public awareness.

YES **NO**

Release of Information and Records

I, and/or my legal guardian hereby authorize Synapse House to release any information related to my treatment, care or related issues to individuals or organizations indicated below. I understand that as a condition of my participation through funding sources such as Dept. of Rehabilitation Services (DRS), potential employers, Worker's Compensation Insurance or grants, that it is required to provide information to these entities as a condition of funding and to meet the criteria set by the program.

I approve the release of information to: _____

Confidentiality and HIPAA

I, and/or my legal guardian have received and understand my rights as specified in the HIPAA guidelines. I also agree to respect and maintain the privacy and confidentiality of all persons served by the organization and the organization as its own entity.

YES **NO**

Member Directory Consent

I, and/or my legal guardian hereby authorize Synapse House to add my phone number and email address to the Member Directory. I understand that upon given access to this document that I will keep the

sudden death. If I experience any of these or any other symptoms while exercising, I will discontinue the activity, notify the Group Instructor, and consult my physician.

- I am participating in the Wellness & Fitness Program with knowledge of the dangers involved. I understand that I will be fully responsible for complying with any restrictions prescribed for me by my personal physician and that I agree to consult my personal physician for further evaluation and such medical care as I require.
- I acknowledge that my participation in the Wellness & Fitness program is at my sole risk. You are advised to consult with your personal physician before participation in the training sessions. The Group Instructor or other fitness staff will not be responsible for monitoring your compliance with your physician's recommendations. Even consultation with your regular physician is in no way a guarantee against the possibility of adverse occurrences during the training sessions.
- In consideration for my voluntary participation in the Wellness & Fitness Program, I, my family, heirs, executors, representatives, administrators, and assigns do hereby waive, release, and forever discharge the company known as Synapse House, and their respective managers/officers, directors, employees, and agents; and my group instructor, from any and all responsibilities, liabilities and lawsuits, present or future, and causes of action for ordinary negligence, whether foreseeable or unforeseeable, arising out of or related in any manner directly or indirectly, to my use of or access of Synapse House Programs.
- This waiver includes, but is not limited to such claims that may result from any injury, illness, or death, accidental or otherwise, during or arising in any way from my participation in any exercise or recreation activity or fitness testing associated with the Wellness & Fitness Program. I hereby agree to expressly assume and accept sole responsibility for the risk of injury or death so long as they are not the result of gross negligence by the company known as Synapse House and/or my Group Instructor.
- I, and/or my legal guardian, agree that I may participate in Wellness and Fitness programs through Synapse House and understand it is the responsibility of the member, family or guardian to inform Synapse House of any restrictions to wellness and fitness activities otherwise I certify that I am capable of performing physical exercise and acknowledge that I am voluntarily participating in this Group Exercise Program.

Wellness and Fitness Restrictions (if any):

YES

NO

Synapse House COVID-19 Policies

I, and/or my legal guardian hereby agree as a participant of Synapse House programs or services to follow the policies that relate to COVID-19 in accordance with the guidelines as set by the State of Illinois and the Dept. of Public Health. This includes:

- Wearing of a mask as mandated
- Regular handwashing & hand sanitizing
- Maintaining social distance as appropriate
- Implementing 10-day self-quarantine if diagnosed or exhibiting symptoms of COVID-19, potentially exposed or following travel to COVID hot spots
- Reporting any potential exposures or positive test results to the organization within 24 hours.

CONSENT & ACKNOWLEDGEMENT

2.01.C

Updated 12/18/21

This document is the property of Synapse House

I, and/or my legal guardian agree to follow these policies and all policies of the organization.

YES **NO**

Consent Form

I, and/or my legal guardian understand that this consent form is valid one year from the signed date and can be modified at any time by the completion of a new consent form. I, or we, understand that participation is contingent on full completion of the form and that services or programs may be suspended if the consent form is incomplete or expired.

YES **NO**

Signature of Person Served OR Legal Guardian

Date

The undersigned legal representative hereby represents that he / she has the legal authority to make health care decisions on behalf of the person served and that a copy of this document has been provided to the organization and that such representation hereby consents on behalf of the person to the consents and acknowledgements listed above.

FOR OFFICE USE ONLY	
BI First Checked & Updated: Member Directory:	Updated by: