**SYNAPSE HOUSE**

**CONSENT & ACKNOWLEDGEMENTS – 6.01.C**

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

***Member Name: Form Provided On:***

**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**

**Virtual Treatment Equipment**

If participating in Virtual Treatment, confirm that you have the necessary technology and equipment, that the equipment is in working order and have the capabilities to utilize for participation.

**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.

**YES NO**

**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 being given access to this document that I will keep the information confidential. I may, at any time, request removal of my information. This directory is not shared with any outside parties.

**YES NO**

**Transportation**

I, and/or my legal guardian will abide by the rules for transportation when being transported by a Synapse House employee in the vans or in the employee’s personal vehicles.

This includes:

* No consumption of food or drink in the van or vehicles. No smoking.
* Wear a seatbelt for the duration of the trip.
* Reduce any distractions to the driver. Please do not touch the radio.
* Call 877-932-1120 to cancel rides. Please do not text the driver if possible.
* Allow a window of 15-20 minutes for pick up or drop off to accommodate for traffic delays.
* Do not ask the driver to drop off at any other location other than an approved stop.
* Please keep the van and vehicles clean by picking up any trash & remembering all personal items.

**YES NO**

**Criminal History**

I, and/or my legal guardian understand that disclosure of criminal history is highly recommended prior to or during the admission process for the organization to provide the best plan of care. Note that all persons will be subject to a background check for sexual offenses.

**YES NO**

**Rights and Responsibilities**

I, and/or my legal guardian understand that as a condition of my care, the organization is responsible to uphold certain rights and fulfill said responsibilities. I, and/or my legal guardian also understand that I(we) are responsible to uphold certain responsibilities and to be respectful of the rights of the organization. The purpose of this agreement is to provide the best care and to maintain a strong mutually beneficial relationship. I, and/or we, agree to rights & responsibilities.

**YES NO**

**Risk Management**

I, and/or my legal guardian understand that during participation of services of Synapse House, that a certain risk may be present for health and safety issues. It is my responsibility to alert the organization to any activity that may increase risk or be potentially harmful. Synapse House requests that all associates, persons served and their guardians work together to reduce or eliminate risk. I, and/or my legal guardian understand these potential risks and my responsibility to communicate concerns.

**YES NO**

**Actions to Reduce Risk:**

**KNZ Gym & NeuroFitness Programs Waiver Form**

* I, and/or my legal guardian acknowledge that a Fitness Program is designed to improve my personal fitness.
* I understand that there may be health risks associated with activities using physical exertion in an exercise program. The health risks include, but are not limited to, transient dizziness, fainting, nausea, muscle cramping, musculoskeletal injury, sprains and strains, heart attack, stroke or 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 **KNZ Gym & NeuroFitness Programs** 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 **KNZ Gym & NeuroFitness Programs** 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 **KNZ Gym & NeuroFitness Programs**, 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 **KNZ Gym & NeuroFitness Programs**. 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 Synapse House and/or my Group Instructor.
* I, and/or my legal guardian, agree that I may participate in **KNZ Gym & NeuroFitness 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 Exercise Program.

**YES** **NO**

**KNZ Gym & NeuroFitness Program Restrictions (if any):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Synapse House Communicable Disease Control 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 or any other communicable disease in accordance with the guidelines as set by the State of Illinois and the Dept. of Public Health. This may include:

* Wearing a mask, if needed
* Regular handwashing & hand sanitizing.
* Implementing self-quarantine if diagnosed, potentially exposed or exhibiting symptoms of COVID-19, RSV, Influenza or any other communicable disease.
* Reporting any potential exposures or positive test results to the organization within 24 hours.
* Alerting staff to any communicable diseases, such as the flu, as this prohibits one from participating in the Culinary Unit and the programs in general.

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**

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Signature of Person Served OR Legal Guardian Date

The undersigned legal representative hereby represents that they have 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: Updated by:

Member Directory: