Above and Beyond Physical Therapy Inc.
CONSENTS

CONSENT TO TREATMENT:

I consent to receive rehabilitation therapy treatment and any supplementary services that are deemed medically necessary or appropriate by my therapist and/or treating physician. However, I understand that the practice of rehabilitation therapy is not an exact discipline and I acknowledge that no guarantees have been made to me regarding treatment and/or the treatment results from the rehabilitation therapy.
I authorize to release any of my medical records, imaging, or surgical reports to Above & Beyond Physical Therapy, Inc. for the purpose of obtaining medical information pertaining to my treatment.
Treatment can be administered based on the physician's diagnosis and certain patients require a prescription throughout the plan of care. It is my responsibility, as the patient, to provide Above & Beyond Physical Therapy with these prescriptions, as needed.
In conjunction with my care, I authorize the use of recording devices, including, without limitation, a camera and/or mobile device to record videos and/or images for the purposes of enhancing my care. In addition, I authorize the transmittal of such recording device videos and/or images to my rehabilitation provider and/or the treating physician through secure email and/or text message. I acknowledge that such videos and/or images will only be used or disclosed for treatment purposes, and that my rehabilitation provider will not further use or disclose such videos and/or images for any other purpose without my written authorization.

X_____ _____
Signature of Patient or Responsible Party Date

NOTICE OF PRIVACY PRACTICES:

Acknowledgment of Receipt

By signing this form, you acknowledge that you have been offered a copy for review of ABPT's Notice of Privacy Practices, which is available at the clinic, with the Physical Therapist or on our website. This NOtice of Privacy Practices provides information about how we may use and disclose your protected health information. Our Notice of Privacy Practice is subject to change. If we change our notice, you may obtain a new copy of the revised notice and if you have any questions about out Notice of Privacy Practice please contact (909) 289-0879

X_____ _____
Signature of Patient or Responsible party Date

*****AUTHORIZATION TO TREAT A MINOR (IF APPLICABLE)***

I, _____, the parent or guardian of _____, minor under the age of 18, permit the healthcare provider at ABPT to evaluate and treat the above minor.

X_____ _____ _____
Signature of Patient or Responsible Party Date Relationship to minor