Sport Performance Liability Waiver

I am aware that exercise and performance associated with any physical activity can be a dangerous and involve many risks or injuries. I understand that the risks of participating in physical activity (exercise or performance) includes, but are not limited to: death, serious neck and spinal injuries which may result in complete or partial paralysis or brain damage, serious injury to virtually all bones, joints, ligaments, muscles, tendons, and other aspects of the musculoskeletal system, and serious injury/impairment to other aspects of my body, general health, and well-being. I understand that Conte Sport Performance Therapy ("CSPT") cannot be held responsible for any injuries/conditions that may be caused by the actions of participation in exercise or performance activities.

Participating in athletic exercise and performance can also result in concussion or mild traumatic brain injury. Concussion related symptoms include, but are not limited to, difficulty in thinking or concentrating, loss of consciousness or memory, balance or coordination deficits, dizziness, headache, nausea, confusion, and sleep disturbances. If I do experience any symptomology of a concussion, I affirm that I will immediately stop and report them to my strength coach or athletic trainer, no matter how minor it appears at the time. I further affirm that I will not participate in any athletic activity until all symptoms have subsided and I have completed the return to play protocol.

Due to the dangers of participating in physical activity, I recognize the importance of following all associated techniques, training, and performance instructions given by the physical therapists, certified athletic trainers, or strength coaches.

In consideration of CSPT permitting me to complete exercise and performance within or outside their facilities (including but not limited to parking lot, field, cages, etc.) I hereby voluntarily assume all risks associated with participation and agree to exonerate and hold harmless CSPT, their officers, agents and employees, the physicians and other practitioners of the healing arts treating me, from any and all liability, claims, causes of action or demands of any kind and nature whatsoever which may arise by or in connection with my voluntary participation. The terms hereof shall serve as a release of any claim or right to pursue a claim by any spouse, child, or any other family members, or my estate, or any other person claiming any right or interest through me.

The undersigned,

(A) Understands and accepts the risks and dangers of voluntarily participating in exercise or performance activities.
(B) Understands common concussion symptoms and the responsibility to report any symptomology immediately,
(C) Understands the importance of and accepts to obey all instructions from physical therapists, certified athletic trainers, and strength coaches.
(D) Attests that this document serves as a release of any claim or right to pursue a claim by any spouse, child, or any other family member, or my estate, or any other person claiming any right or interest through me.
(E) Understands that she/he must refrain from athletic performance during medical treatment until she/he is discharged from treatment, or given permission by physician, physical therapist, athletic trainer, or strength coach to resume participation despite continuing treatment,
(F) Understands that having passed a physical examination does not necessarily mean that she/he is physically qualified to engage in athletics, only that the examiner did not find a medical reason to disqualify her/him at the time of examination.
(G) Understands and agrees that if injury/illness does occur that it is the responsibility of the athlete to notify a CSPT Staff member and adhere to treatment/return to play guidelines.
(H) Understands that she/he must wear proper equipment/protective padding/bracing as dictated by the rules of sport or by CSPT Staff member.

Client Name Printed _____ Date of Birth _____

Client Signature _____ Date _____

Parent/Legal Guardian Signature (If Under 18) _____ Date _____

New Client Paperwork

Client Name (First and Last): _____

Date of Birth: _____ **Age**: _____ **Phone**: _____

Email Address: _____

Address: _____

City: _____ **State**: _____ **Zip Code**: _____

Team Name: _____ **Position**: _____

Emergency Contact Name: _____

Relationship to Client: _____ **Phone**: _____

Financial Policy and Payments:

Weekly packages will be charged on the first day of attendance during the respective week. CSPT accepts payments through cash, check, credit, or Venmo. Payments should be paid on Monday or the patient's first day of attendance. Attendance is the patient's responsibility. No-shows or cancellations will not be refunded. Patient accounts carrying a balance longer than 30 days are subject to a minimum monthly payment of $75 or 25% of the outstanding balance due, whichever is larger. There is a $50 service fee for all returned checks. Past due accounts are subject to collection proceedings. All fees including but not limited to collection fees, attorney fees, and court fees shall become the patient's responsibility in addition to the balance due to this office.

_____ _____

Client Signature Date

_____ _____

Parent/Legal Guardian Signature (If Under 18) Date

Media Consent and Release:

I hereby give unconditional and irrevocable permission and authority to Conte Sports Performance Therapy LLC to make audio, video, and still recordings of myself (or minor if signer is under the age of 18, such person being referred to as "Subject") and to use the Subject's image, video, name, and/or description in any and all advertising, social media usage, marketing, and/or promotional campaigns related to Conte Sports Performance Therapy LLC. I also hereby release Conte Sports Performance Therapy LLC from any liability resulting from reproduction or distribution of advertising, social media usage, marketing, and/or promotional materials using the Subject's image, video, audio, name, and/or description. This consent and release are given without any promise of compensation or reimbursement.

_____ _____

Client Signature Date

_____ _____

Parent/Legal Guardian Signature (If Under 18) Date