Back to You
Physical Therapy & Sports Medicine

COVID-19 CONSENT FORM

Date: _____

Patient Name:_____ DOB: _____

- ☐ I understand that I am receiving Physical Therapy during the events of a Covid-19 National Emergency.
- ☐ I understand that there may be a risk in being in proximity of Physical Therapists, patients, or staff.
- ☐ I understand that Back to You Physical Therapy is taking precautions to limit the spread of the disease, yet there is still a possibility of transmission.
- ☐ I agree not to hold my treating Physical Therapist, or any employees working for Back to You Physical Therapy and Sports Medicine Inc. liable for my actions, or liable for any negative results or symptoms that can develop due to treatment.
- ☐ I understand that I may reconsider my decision at any time.

Patient Signature: _____

Printed Name: _____

I consent to treatment during the Covid-19 Emergency.

By checking this box, I am certifying that I have discussed my care options with my physical therapist, including the option of telehealth physical therapy, and I am choosing to participate with "in clinic" care. By my signature below, I attest that I have been made aware of the options available and have determined that in-clinic physical therapy is essential to my best results. I personally and solely accept the associated risk of disease transmission and potential consequence.

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