CONSENT TO PHYSICAL THERAPY TREATMENT

Response to physical therapy intervention varies from patient to patient; it is not possible to accurately predict your response to specific procedure, exercises or modality including but not limited to techniques such as: Blood flow restriction therapeutic exercise, kinesiology taping, trigger point dry needling, electrostimulation, instrument assisted soft tissue mobilization, manual therapeutic cupping, muscle and joint flossing and other therapeutic techniques involving joint mobilizations. No physical therapist can guarantee what your reaction may be to a specific treatment or that the treatment will help resolve the condition you are seeking treatment for. It is possible that treatment may result in aggravation of current and existing symptoms as well as increased pain.

It is your right to decline any part of your treatment at any time, before and/or during treatment should you feel discomfort or have other concerns.

It is your right to discuss with your physical therapist about the treatment, including potential risks or benefits, based on your history, physical therapy diagnosis, symptoms and examination results.

I have read this consent form and understand the potential risks involved in physical therapy. I understand that the success of my treatment depends on my ability and willingness to cooperate and participate in the physical therapy procedures and comply with the established plan of care.

I authorize the release of medical information to appropriate third parties

What this means in plain English:

We are a group of highly skilled medical professionals and we will use our best judgment and expertise to help with your problem. Some of the treatments we will work on may cause increased pain and we will make all efforts to minimize that. Sometimes, no matter how good we are at our jobs, Physical Therapy cannot help you. It usually makes sense to try Physical Therapy treatment before considering more invasive or risky options like medication, injections or surgery

CONSENT TO TELEHEALTH

Revolution Sport & Spine Therapy is providing telehealth services for consultation, treatment and education when in-office or face-to-face visits are unable to occur. Health information is exchanged interactively though electronic communications; this includes but is not limited to: videoconferencing, telephone consultation and e-health technologies.

I consent to participating in telehealth for physical therapy examination, establishing a treatment plan and applicable treatment/interventions to address my current symptoms through and electronic or technology-assisted format.

I understand that there are limitations in providing these services without a physical presence from the treating professional. In some cases, we may advise you to attend an in-person office visit or refer you to a more appropriate medical professional.

I understand that with electronic communications and videoconferencing that Revolution Sport & Spine Therapy is using doxy.me as a HIPAA compliant communication platform. Though all medical communications carry some level of risk, Revolution Sport & Spine Therapy has taken prudent measures to reduce possible breaches. The healthcare provider and practice, Revolution Sport & Spine Therapy, is not responsible for breaches of confidentiality caused by an independent third party or by me.

To the extent permitted by law, I agree to waive and release my healthcare provider and Revolution Sport & Spine Therapy LLC from any claims I may have regarding Physical Therapy services delivered via telehealth.

What this means in plain English:
We would prefer to see you in-person, but in certain circumstances that is not possible (like with COVID-19). We can still provide great help, education and treatment suggestions using high-tech video communication. We do our best to keep your medical information secure, but using the internet adds additional risk.

CONSENT FOR PHOTO/VIDEO RELEASE

I hereby grant Revolution Sport & Spine Therapy, its parties/representatives and employees the unlimited right and permission to use in perpetuity my photograph, video, audio, actions, and/or testimonial for any and all lawful purposes. This irrevocable right and permission to use my likeness, with or without my face or name, in photographs/videos, and in all forms and media (including, but not limited to: all avenues of social media, website, any publications and/or advertising and promotion) may be used for education, trade, all forms of publicity, illustration or any lawful purpose.

By signing below, I agree to release any right I may have to inspect and/or authorize the finished product(s) and waive any right to control the use of said product(s). I agree not to make any monetary, liability, compensation or any type of claim.

What this means in plain English:
We sometimes use video or photographs during treatment to analyze movements or walking – usually without your face showing. If you do something amazing in therapy, we may ask to take a photo or record it and use it to promote our business. If you verbally agree to that, you agree not to change your mind later or sue us. We do not randomly take any pictures or video and use it without asking.

_____ _____

Patient or Legal Guardian Signature *Relationship to Patient*

_____

Date