Complete Home Therapy

"Therapy where you need it most"

Informed Consent and Liability Release

Consent for Purposes of Treatment, Payment and Healthcare Operations:

I consent that **COMPLETE HOME THERAPY** "**CHT**" may release information for purposes of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations by this Home Care Based Outpatient clinic. This information includes information that is collected from you, created or received by a physician or another health care provider, and information received from a health plan, an employer or a health care clearinghouse. _____

I understand I have the right to request a restriction as to how my protected health information is used or disclosed. CHT is not required to agree to the restrictions that I may request. However, if CHT agrees to a restriction that I request, the restriction is binding to CHT. I have the right to revoke this consent, in writing, at any time. _____

The term "informed consent" means that the potential risks, benefits and alternatives of physical therapy treatment have been explained to me. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition. _____

I have been informed of and acknowledge that participation in physical exercise involving flexibility, strength, balance, agility, and aerobic exercise, including the use of equipment and devices, is a potentially hazardous activity. I have also been informed of and acknowledge that participation in physical therapy can be a test of a person's physical and mental limits and that such participation and training poses potential risks of serious bodily injury or death. _____

I HEREBY ACCEPT THE RESPONSIBILITY FOR ANY HARM, INJURY OR DAMAGE THAT MAY RESULT FROM MY PARTICIPATION IN BALANCE ENHANCEMENT TESTING OR TRAINING. I HEREBY WAIVE, RELEASE, ABSOLVE, INDEMNIFY AND AGREE TO HOLD CHT, ITS OFFICERS, EMPLOYEES AND AFFILIATES FOR ANY CLAIM ARISING OUT OF ANY INJURY TO ME. I VOLUNTARILY AND KNOWINGLY ACKNOWLEDGE, ACCEPT AND ASSUME THESE RISKS. _____

_____

Patient Name (Print) Signature Date

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Other Responsible Party Name (Print) Signature Date