Elite Performance And Therapy

284 Central Way | Kirkland, WA | 98033 | Ph (425) 999-4484 | Fx (425) 999-4484

Patient Intake Forms

Patient Name: _____
First *Middle* *Last*

Address: _____

City: _____ State: _____ Zip: _____

Contact Number: _____ ○ Home ○ Cell ○ Work

Alternate Number: _____ ○ Home ○ Cell ○ Work

Email: _____ **Sex**: ○ M ○ F

Date of Birth: _____ / _____ / _____ **Social Security #:** _____ / _____ / _____

Marital Status: ○ Single ○ Married ○ Partner ○ Divorced ○ Widowed ○ Child

Name of Spouse: _____ **Occupation:** _____

Number of Children: _____ **Name(s) & Age(s):** _____

Employment: ○ Employed ○ F/T Student ○ P/T Student ○ Retired ○ Other : _____

Employer: _____ **Occupation:** _____

Insurance Company: _____ **ID#:** _____

Insurance Subscriber: _____ **Birthdate:** _____ / _____ / _____

In case of Emergency Contact: _____
Name *Relationship*

Cell Phone: _____ **Alternate Phone:** _____

Referred to our office by: _____

Assignment of Benefits: I hereby assign and grant the benefits which I am eligible to receive for professional services rendered in this office to Elite Performance And Therapy. I authorize the release of any medial information necessary to process any insurance claims for payment. I understand I am financially responsible for any charges not paid by my insurance.

X _____ _____
Signature (Patient or Parent/Guardian) *Date*

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Insurance Verification Page

For the most accurate benefit information we request patients contact their insurance directly.

Please use this form for reference when contacting your insurance company to confirm your physical therapy (PT) benefits at our office. Please note it is the responsibility of you, the patient, to know your insurance benefits when receiving treatment from our office.

Effective Date: _____ Yearly Deductible: _____

Does my policy renew on a calendar year? ◯ Yes ◯ No, renews: _____

Is PT a covered benefit under my plan? ◯ Yes* ◯ No

*If yes, is my coverage combined with other therapies? _____

How many visits are allowed under my insurance plan for PT? _____

Is authorization required for PT? ◯ Yes* ◯ No

*If yes, when is authorization is required? _____

Does my deductible apply to PT? _____

Do I have a copay or co-insurance for PT? _____

What is my maximum out of pocket? _____

Reference # from call: _____ *Patient Signature*: _____

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A. Health History

Patient Name: _____ **Date:**_____

Patient Lives With: ◯ Roommate ◯ Parents ◯ Alone ◯ Assisted Living
◯ Spouse ◯ Children ◯ Other: _____

Patient's Complaints: ☐ Physical examination with no complaints.

Mark your present complaints for:

NECK AND BACK	*Side*	*Pain*	*Numbness*	*Tingling*	*Stiffness*	*Swelling*	*Weakness*	*Mild*	*Moderate*	*Severe*	*Burning*	*Dull*	*Sharp*	*Shooting*	*Aching*	*Throbbing*	*Occasional*	*Intermittent*	*Frequent*	*Constant*	*Improving*	*Worsening*	*Unchanged*	*Resolved*
Neck	L																							
	R																							
Upper Back	L																							
	R																							
Mid Back	L																							
	R																							
Low Back	L																							
	R																							
Ribs	L																							
	R																							

When did you neck/back complaint begin? _____ / _____ / _____

UPPER BODY	*Side*	*Pain*	*Numbness*	*Tingling*	*Stiffness*	*Swelling*	*Weakness*	*Mild*	*Moderate*	*Severe*	*Burning*	*Dull*	*Sharp*	*Shooting*	*Aching*	*Throbbing*	*Occasional*	*Intermittent*	*Frequent*	*Constant*	*Improving*	*Worsening*	*Unchanged*	*Resolved*
Shoulder	L																							
	R																							
Arm	L																							
	R																							
Elbow	L																							
	R																							
Forearm	L																							
	R																							
Wrist	L																							
	R																							
Hands And Fingers	L																							
	R																							

When did your upper extremity complaint begin? _____ / _____ / _____

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LOWER BODY	Side	Pain	Numbness	Tingling	Stiffness	Swelling	Weakness	Mild	Moderate	Severe	Burning	Dull	Sharp	Shooting	Aching	Throbbing	Occasional	Intermittent	Frequent	Constant	Improving	Worsening	Unchanged	Resolved
Hip	L																							
	R																							
Buttock	L																							
	R																							
Thigh	L																							
	R																							
Knee	L																							
	R																							
Leg/Calf	L																							
	R																							
Ankle	L																							
	R																							
Foot	L																							
	R																							

When did your lower extremity complaint begin? _____ / _____ / _____

B. Patient Complaints

1. How did your complaints begin?…….…. ☐ Unknown ☐ Suddenly ☐ Gradually

2. What happened to cause or re-aggravate your complaint(s)?

☐ Unknown ☐ Auto accident ☐ Personal injury ☐ Work accident/Injury
☐ Home accident ☐ Sports injury ☐ Other: _____

_____

3. How would you rate your pain today? [0 = no pain and 10 = worst pain]

No pain 0◯ 1◯ 2◯ 3◯ 4◯ 5◯ 6◯ 7◯ 8◯ 9◯ 10◯ *Worst pain possible*

4. When are your symptoms worse?

☐ Always the same ☐ Morning ☐ Afternoon ☐ Evening ☐ Night

5. What makes your condition better? ☐ Nothing ☐ Rest ☐ Heat
☐ Stretching ☐ Sitting ☐ Exercise ☐ Standing ☐ Ice
☐ Medications ☐ Other: _____

6. What makes your condition worse? ☐ Nothing ☐ Coughing ☐ Reaching
☐ Standing ☐ Sneezing ☐ Lifting ☐ Sitting ☐ Pulling
☐ Bending ☐ Walking ☐ Straining ☐ Turning
☐ Other: _____

7. Have any of your complaint(s) existed in the past?..... ◯ No ◯ Yes *(Please indicate below)*

☐ Ribs	☐ Neck	☐ Upper back	☐ Mid back	☐ Low Back
☐ Wrist	☐ Forearm	☐ Elbow	☐ Arm	☐ Shoulder
☐ Knee	☐ Hip	☐ Thigh	☐ Hands/Fingers	☐ Buttock
☐ Food	☐ Ankle	☐ Leg/Calf	☐ Other: _____	

8. Have you had any recent treatment for your condition <u>outside</u> of this office? ◯ No ◯ Yes

If yes, list dates, treatments and doctors: _____

_____

_____

9. Since your symptoms began, have you noticed a change in:

☐ Bowel function ☐ Bladder function ☐ Sexual function ☐ No to all

C. Headaches

<u>If you are experiencing headaches, please fill out this section</u> otherwise skip to section D below.

1. Where is the pain located in association with your headache?

☐ Left side of head	☐ Right side of head	☐ Base of skull	☐ Left jaw joint
☐ Right jaw joint	☐ Over eyes	☐ Behind eyes	☐ Over sinuses

2. On what date did your headaches begin? _____ ☐ Same as neck/back complaints

3. How does the intensity if your headaches rate?

No pain 0◯ 1◯ 2◯ 3◯ 4◯ 5◯ 6◯ 7◯ 8◯ 9◯ 10◯ Worst pain possible

4. What describes your pain?.... ☐ Dull ☐ Sharp ☐ Deep ☐ Aching ☐ Stabbing

☐ Vice-like ☐ Burning ☐ Throbbing/Pulsating ☐ Other: _____

5. When do your headaches usually start?

☐ Constant ☐ Midday ☐ Evening ☐ Wake up with in the morning.

6. What seems to bring on your headaches?

☐ Alcohol ☐ Certain foods ☐ Menstrual period ☐ Physical activity

☐ Caffeine ☐ Excessive stress ☐ Other: _____

7. How often do they occur? ☐ Daily ☐ Weekly ☐ Monthly ☐ Other: _____

8. How long do your headaches last?..... ☐ Less than an hour ☐ 1-3 hours ☐ 3+ hours

☐ Several hours to days ☐ All waking hours ☐ Other: _____

9. Do your headaches wake your from your sleep?..... ☐ Yes ☐ No ☐ Sometimes

10. Do any of the following occur with your headaches?

☐ Nausea/Vomiting ☐ Nausea/Vomiting ☐ Dizziness ☐ Weakness
☐ Light/Sound sensitivity ☐ Vision problems ☐ Tremor ☐ Other: _____

11. What makes your headaches better?

☐ Massage ☐ Rest ☐ NSAIDS *(Aspirin, Tylenol, etc.)* ☐ Lying down
☐ Standing ☐ Ice ☐ Nothing ☐ Other: _____

D. Other Complaints

Do you have any other complaints not covered on this form? ☐ No ☐ Yes *(Please describe)*

_____

_____

_____

E. Review of Symptoms

Are you currently suffering from any of the symptoms listed below?

☐ **None of the symptoms listed below**

☐ General fatigue (*chronic*)
☐ Weakness
☐ Fever *(continuous)*
☐ Loss of sleep
☐ Chills *(continuous)*
☐ Weight change (u*nexplained)*
☐ Night sweats
☐ Headaches
☐ Dizziness
☐ Fainting
☐ Convulsions
☐ Nervousness
☐ Anxiety
☐ Depression *(prolonged)*
☐ Phobias
☐ Memory loss
☐ Mood swings (*excessive*)

☐ Wheezing (*chronic*)
☐ Difficulty breathing
☐ Swollen extremities
☐ Blue extremities
☐ Varicosities *(visible veins)*
☐ Rapid heart beat
☐ Chest pain
☐ Heart palpitations
☐ Heart murmur
☐ Decreased appetite
☐ Increased appetite
☐ Abdominal pain
☐ Hemorrhoids
☐ Excess gas
☐ Vomiting (*excessive*)
☐ Diarrhea (*excessive*)
☐ Constipation (*excessive*)

☐ Goiter (*enlarged thyroid gland*)
☐ Tremor *(shaking)*
☐ Redness of skin
☐ Skin itching
☐ Urinary retention
☐ Bed-wetting
☐ Sterility
☐ Impotence
☐ Other: _____

☐ Hearing trouble ☐ L ☐ R
☐ Ringing in ears ☐ L ☐ R
☐ Pain in ears ☐ L ☐ R
☐ Ear discharge ☐ L ☐ R
☐ Vision trouble ☐ L ☐ R
☐ Pain in eyes ☐ L ☐ R
☐ Eye discharge ☐ L ☐ R

- ☐ Nose/sinus pain
- ☐ Excessive drainage
- ☐ Nose bleeds, chronic
- ☐ Absence of smell
- ☐ Skin rash
- ☐ Skin dryness
- ☐ Eczema *(red, inflamed skin)*
- ☐ Hair changes (*unplanned*)
- ☐ Nail changes (*unplanned*)
- ☐ Bruise easily
- ☐ Cough, chronic
- ☐ Heartburn/Indigestion
- ☐ Painful urination
- ☐ Mouth sores
- ☐ Bleeding gums
- ☐ Enlarged glands
- ☐ Absence of taste
- ☐ Abnormal taste sensation
- ☐ Tonsillitis/Infected tonsils
- ☐ Difficult swallowing
- ☐ Heat/cold intolerance
- ☐ Sugar in urine

WOMEN ONLY:

- ☐ Irregular menstruation
- ☐ Painful menstruation
- ☐ Abnormal vaginal bleeding
- ☐ Lumps in breasts
- ☐ Redness/Itching of breasts
- ☐ Dimpling of breasts
- ☐ Discharge from breasts
- ☐ Breast pain
- ☐ Other: _____

F. Habits/Activities

What are your current habits?

Smoking *packs/day*……..…….. ○ None ○ <1 ○ 1-2 ○ 2-3 ○ 3-4 ○ 5+

Caffeinated drinks *glasses/day*……. ○ None ○ <1 ○ 1-2 ○ 2-3 ○ 3-4 ○ 5+

Alcoholic drinks *glasses/day*…..…. ○ None ○ <1 ○ 1-2 ○ 2-3 ○ 3-4 ○ 5+

Drug/Substance Abuse……..…….. ○ No ○ Yes…. **If yes, discuss with doctor**

Exercise *days/week*…….……..…. ○ None ○ <1 ○ 1-2 ○ 2-3 ○ 3-4 ○ 5+

Kinds of exercise you do:

☐ Walking ☐ Jogging ☐ Cycling ☐ Swimming ☐ Strength training

☐ Tennis ☐ Golf ☐ Other: _____

G. Medical History

1. HEALTH CARE

A. Have you ever been to a chiropractor?…...…….……..…….. ○ Yes ○ No

B. Do you have a family physician?…….…….……..……...…….. ○ Yes ○ No

Date of last physical exam:_____ Phone #: _____

Physician's name: _____ Email: _____

Address: _____

C. Have you been hospitalized in the past?…...…….……..…… ○ Yes ○ No

If yes, date and reason for hospitalization: _____

_____

D. Have you ever had surgery?…..……..…….……..……. ◯ Yes ◯ No

If yes, date, reason and results of surgery: _____

_____

E. Have you ever had a serious accident/injury?..…….…….…….. ◯ Yes ◯ No

List date and description of injury:

☐ Auto: _____ ☐ Personal: _____

☐ Work-related: _____ ☐ Sports injury: _____

☐ Other: _____

F. Are you currently taking any vitamins minerals and/or herbs?…….…… ◯ Yes ◯ No

If yes, list supplements: _____

_____

G. Medical History Continued

G. Are you currently taking any medications? ……..…… ◯ Yes ◯ No

For what condition(s) are you taking any medications?

☐ Anti-inflammatory *Aspirin, Ibuprofen, Motrin, etc.*: _____

☐ Pain/Analgesics: _____

☐ Anti-depressants: _____

☐ Muscle relaxants: _____

☐ Blood pressure pills: _____

☐ Antibiotics: _____

☐ Birth control pills: _____

☐ Corticosteroids: _____

☐ Other: _____

In the past have you used any of the following? ☐ Birth control pills ☐ Corticosteroids

G. Are you currently allergic to any medications?……..……... ◯ Yes ◯ No

If yes, please list medications: _____

_____

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To your knowledge, are you pregnant?……..……..……..…… ◯ Yes ◯ No

If pregnant in the past, were pregnancies normal?……..…..…… ◯ Yes ◯ No

Are you seeing an OB-GYN regularly?……..……..……..…. ◯ Yes ◯ No

Number of births? ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ Other _____

Date of last exam: _____ / _____ / _____

Physician's name: _____

G. Medical History Continued

2. FAMILY HISTORY

	Cancer	*Diabetes*	*Heart Trouble*	*Hypertension*	*Stroke*	*Kidney Disease*	*Anemia*	*Mental Illness*	*Headaches*	*Osteoporosis*	*Arthritis*	*Scoliosis*	*Back Problems*	*Disc Problems*	*Congenital Defects*	*Genetic Disease*	*Other*	*Deceased*
Father																		
Mother																		
Brother																		
Sister																		
Children																		

Describe others: _____

3. CONDITIONS OR ILLNESSES

Please indicated if you have now or have had in the past any of the following illnesses:

☐ No current or previous conditions/illnesses

NOW HAVE	IN PAST		NOW HAVE	IN PAST		NOW HAVE	IN PAST	
☐	☐	Sinus trouble	☐	☐	Dizziness/Fainting	☐	☐	Rheumatic fever
☐	☐	Hay fever	☐	☐	Epilepsy/Seizures	☐	☐	Polio
☐	☐	Allergies	☐	☐	Thyroid trouble	☐	☐	Multiple sclerosis
☐	☐	Emphysema	☐	☐	High blood pressure	☐	☐	Ulcer
☐	☐	Tuberculosis	☐	☐	Low blood pressure	☐	☐	Liver trouble
☐	☐	History of infection	☐	☐	Heart trouble	☐	☐	Kidney trouble

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NOW HAVE	IN PAST		NOW HAVE	IN PAST		NOW HAVE	IN PAST	
☐	☐	Fever (continuous)	☐	☐	Pacemaker	☐	☐	Urinary retention
☐	☐	Cancer /Tumor	☐	☐	Stroke (date): _____	☐	☐	Frequent urination
☐	☐	Diabetes	☐	☐	Aortic aneurism	☐	☐	Prostate trouble
☐	☐	Visual disturbances	☐	☐	Osteoporosis	☐	☐	Dislocated joints
☐	☐	Scoliosis	☐	☐	Spinal disease	☐	☐	Arthritis
☐	☐	Bonefractures	☐	☐	Abnormal weight gain	☐	☐	Anemia
List & dates: _____			☐	☐	Abnormal weight loss	☐	☐	Sex. Trans. disease
_____			☐	☐	Numbness groin/buttocks	☐	☐	HIV
_____			☐	☐	Mental/emotional difficulty	☐	☐	AIDS/ARC

H. Occupational Information/Activities of Daily Living

1. Are you right or left handed? …….……..……..…… ◯ Right ◯ Left

2. Occupation: _____ **3. Hours/Week:** _____

4. How many years have you been in this occupation?

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8
◯ 9 ◯ 10 ◯ 20 ◯ 30 ◯ 40 ◯ 50 ◯ Other: _____

5. Do your present complaints affect the number of hours you work per day? ……. ◯ Yes ◯ No

6. What is your primary work position and location?

Work position: ◯ Seated ◯ Standing ◯ Other: _____

Work location: ◯ Desk ◯ Counter ◯ Workbench ◯ Other: _____

7. What movements does your job require? ☐ Repetitive hand use ☐ Walking ☐ Turning
☐ Carrying ☐ Stooping ☐ Twisting ☐ Bending ☐ Other: _____

8. Does your job involve lifting? ◯ Never ◯ Occasionally ◯ Intermittently ◯ Frequently ◯ Constantly

How many pounds? ◯ <10 ◯ 10-25 ◯ 26-50 ◯ 51-75 ◯ 76-100 ◯ 100+

9. What best describes your stress level at work? ◯ None ◯ Minimal ◯ Moderate ◯ Extreme

10. How do you rate your physical activity at work?…….. ◯ Light ◯ Moderate ◯ Heavy

11. Do your work activities aggravate your current complaint(s)?…….. ◯ Yes ◯ No

If yes, please explain: _____

x _____ _____

Signature (Patient or Parent/Guardian) *Date*

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HIPAA Policy

Notice Of Privacy Practices This Notice of Privacy Practices describes how we may collect, use and disclose your personal information, and your rights regarding that information. Under the Health Insurance Portability and Accountability Act of 1996, health care providers must take measures to protect the privacy of your personal information.

We are required by law to:

- Protect the privacy of personal information.
- Provide this Notice explaining our duties and privacy practices.
- Abide by the terms of this notice.

Ways We Protect Your Personal Information Staff of McCracken Chiropractic & Wellness Center are the only allowed persons granted access to records and use of personal information to the extent necessary to conduct the practice of healthcare services. The building is secured at the end of each business day, along with patient charts and computer records. Our staff has been trained on our written confidentiality policy and procedures and will subject to discipline if they are violated. Your privacy will be protected even if you no longer a patient; old documents are shredded prior to discarding.

How We Collect Your Personal Information Your information is used to determine appropriate care during your treatment here. The use of patient information (such as x-ray records and/or charting information) may be used to determine and render the best chiropractic treatment. We may share this information with other chiropractic specialists to assist in determining your treatment. Social Security numbers, birth date and/or employer information may be used to identify you with healthcare insurance groups. Your phone number(s) and/or address will only be used to communicate with you regarding appointments and/or billing for services. Unless otherwise requested, we may NOT discuss your information with immediate family such as a spouse of sibling. The Minors/dependents may be discussed with parents. We may be ordered by the Court in some unusual situations to release information and do so if it is required.

Your Rights As A Patient You may inspect records we retain regarding personal information and amend them if you feel they are in error. You may request we restrict the sharing of your information except on a case-by case basis. You may request we only contact you at specific locations, i.e. work. You may also request records; we may charge a reasonable fee for this service. You may ask questions regarding your Personal information here.

Acknowledgement Of Privacy Practices By signing below, you have reviewed the Privacy Practices notice as required by HIPAA, and have been given the opportunity to ask questions.

x _____ _____

Signature (Patient or Parent/Guardian) *Date*

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Financial Policy Agreement

Thank you for choosing us as your health care provider. We are committed to the success of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to treatment. If at any time you have questions regarding any treatment, fee, or service, please discuss them with us promptly and frankly. We will make every effort to avoid a misunderstanding or rectify an injustice.

Insurance As a courtesy, we will bill your insurance carrier for you. All co-payments, deductibles, and payments for supplements, supports, and other "non-covered" services are due at time of service unless prior arrangements have been made. We DO NOT do not accept nor will we bill Molina, Medicaid, DSHS or Community Health Plan. You as the patient will be responsible for these balances. Payments may be made by cash, check or credit card/debit cards. If you are unable to pay in full, it is your responsibility to contact our billing department to set up an agreeable payment plan. Your insurance policy is a contract between you and your insurance company. We are not a party to this contract. Pre-authorization is required for certain insurance plans. The following plans that require this are: Regence (CareCore), United Healthcare (Optum), and Cigna (Healthways/Whole Health Pro). If treatment is determined by insurance to be non-medically necessary the patient will be responsible for the treatment balance.

Payments All payments are due at the time of service unless prior arrangements are made. Payments may be made by cash, check or credit/debit cards. Cash rates are subject to change.

Usual and Customary Rates (UCR) Our practice is committed to providing the best treatment possible. Charges will be issued based on usual and customary fees for services in our area. You are responsible for payment in full, regardless of any insurance company's arbitrary determination of usual and customary rates.

Injuries/Accidents Involving Litigation I, hereby authorize the use and/or disclosure of my health information to the claims representative. Our office will make every effort to recover our fees from all available sources, including your health insurance and any med-pay benefits which are available on your auto insurance policy. We will then wait to collect any unpaid balances until after a settlement is reached. It must be understood however, the payment of the balance is ultimately your responsibility.

Worker's Compensation Our office will file worker comp. claims however; it is your responsibility to contact your employer to establish a worker's compensation claim. If the claim is denied, we will bill your personal health insurance carrier. If the claim is unsettled or unpaid within 90 days, you will receive a statement from our office.

Minor Patients Minors must be accompanied by a parent/guardian at the time of the first visit. The parent/guardian accompanying the minor is responsible for payment of the account.

Medicare We accept Medicare assignment. We will file the claim to any secondary insurance which you may have. As the patient your will be responsible for any balance after the insurance processes your claim. Medicare plans will require MD referrals from a preferred provider. These authorizations do not guarantee payment.

Missed and Cancelled Appointments 24 hours' notice is required when cancelling your appointment. Arriving 10-15 minutes past your appointment time will result in a missed appointment. A $35 charge will be collected from the patient for appointments are missed and/or not cancelled within 24 hours or 1 business day.

Patient Statement I have read and understand the Financial Policy Agreement of Elite Performance And Therapy. I understand I am ultimately responsible for payment of any service or product received at this office. I understand I will be responsible for any fees related to collecting my unpaid balance, including reasonable attorney fees.

x _____ _____

Signature (Patient or Parent/Guardian) *Date*

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Confidentiality Agreement

At Elite Performance And Therapy, we place high value on keeping private the personal and sensitive information about our patients' medical conditions. This includes information which is in the medical record, as well as what is spoken between the therapist and patient and even what is directly observable by being in the presence of the patient and the therapist in treatment. The trust which is established between the patient and the therapist is a very important part of the therapeutic process and needs to be protected.

I, _____, understand the importance of confidentiality in regards to the patients of Elite Performance And Therapy and will keep private all information about patients that I see, read, or hear and will not discuss any specific identifying details thereof with anyone outside of Elite Performance And Therapy. This information includes, but is not limited to, the patients' name, date of birth, identifying number(s), gender, or any specific individual patient.

I also understand the importance of confidentiality when it comes to the Trademark secrets, business, business affairs, administrative records, paperwork, and all communications with Elite Performance And Therapy.

_____ _____

Printed Name (Patient or Parent/Guardian) *Date*

_____

Address

x _____

Signature (Patient or Parent/Guardian)

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Consent for Treatment

I hereby request and consent to physical therapy treatment(s) and procedures performed by Heidi Kodeski and/or any associate working under Heidi Kodeski at Elite Performance And Therapy. Treatment may include various physical therapies, massage and/or at home exercises to be performed on/by myself (or the patient named below for whom which I am legally responsible for).

I have been given the opportunity to discuss any questions and/or a concern I may have in regards to my treatment and the practice of physical therapy. I understand that with any medical treatment, there are some risks associated. Risks may include but are not limited to fractures, disc injuries, strokes, dislocations, sprains, temporary soreness, bruising, and/or discoloration.

I understand and am informed that results from treatment may vary and are not guaranteed. In addition, I understand my compliance with dietary recommendations, supplements, prescribed exercises, and/or lifestyle modifications will increase the effectiveness of my care and enhance or maintain my results. I understand a referral to another physician or specialist may be necessary due to the nature of my condition and limitations within the scope of physical therapy.

I have been informed some techniques such as neuromuscular re-education, graston, and/or myofascial release may involve working on muscles located near the breasts, buttocks, and/or groin area. Special care will be exercised in keeping sensitive areas draped during such procedures. If at any time I am uncomfortable with the work being performed, I will verbally inform the provider before or during the treatment. A written documentation of my request will be noted within my chart which will then be signed by me the patient, the doctor, as well a witness at the time of treatment.

I do not expect the provider to anticipate and or explain all risks and/or complications. I will rely upon the provider's professional opinion and judgment to determine the best course of care.

I have read (or have had the above information read to me), understand, and consent to the terms of treatment performed by Elite Performance And Therapy. I (or the patient whom which I am legally responsible for) have been given the opportunity to address questions/concerns regarding my consent for treatment. By signing below, I agree to the terms outlined within this document and give consent for the entire course of treatment related to the present condition and/or future condition(s) for which I may seek treatment.

	x
Printed Name *(Patient or Parent/Guardian)*	*Signature* *(Patient or Parent/Guardian)*
Date	*Witness (Staff signature)*