**PATIENT CONSENT AND INTAKE FORM**

**The Sharp End Physical Therapy**

Patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I CONSENT TO PHYSICAL THERAPY TREATMENT** and related services from The Sharp End Physical Therapy PLLC. I acknowledge and affirm that physical rehabilitation and related services may involve bodily contact, touch and/ or direct contact of a sensitive nature. Initials\_\_\_\_\_\_\_\_\_\_\_\_\_

**LIABILITY.**  I know and agree that The Sharp End Physical Therapy is not responsible for loss or damage to personal belongings or valuables. Initials\_\_\_\_\_\_\_\_\_\_\_\_\_

**TREATMENT OF MINORS.**

I, as the parent of a minor receiving treatment, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. Initials\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WAIVER AND RELEASE**

I hereby release, discharge and acquit: The Sharp End Physical Therapy PLLC, its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services. Initials\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FINANCIAL POLICY, AUTHORIZATION OF PAYMENT**

I understand that The Sharp End Physical Therapy PLLC is a cash-based business. I agree to pay the agreed upon fee at the time of service by Cash, Check or other mutually agreed upon method of payment delivery. Initials\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RELEASE OF RECORDS**

I authorize release of any medical records to other healthcare providers as necessary to facilitate my treatment and communication with other healthcare providers. Initials\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTICE OF PRIVACY/ PATIENT BILL OF RIGHTS**

I acknowledge receipt of Notice of Privacy Practices Initials\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I acknowledge receipt of the Statement of Patient Rights Initials\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that all of the information provided herein is true and correct.

Patient/ Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signiature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_