Consent to Physical Therapy Evaluation and Treatment

I, ____(patient full name), hereby consent to the evaluation and treatment of my condition by a licensed physical therapist employed by FourEight Fitness, LLC DBA CrossFit PAX. The physical therapist will explain the nature and purposes of these procedures, evaluation, and course of treatment. The physical therapist will inform me of expected benefits and complications, and any discomforts, and risk that may arise, as well as alternatives to the proposed treatment and the risk and consequences of no treatment.

Payment for Services

I understand that it is my responsibility to pay in full for all services provided by a licensed physical therapist at CrossFit Pax Physical Therapy. I understand that FourEight Fitness, LLC DBA CrossFit PAX will not be responsible for billing my insurance. I may request information to submit insurance claims for reimbursement on my own.

Patient Information Consent Form

I understand that FourEight Fitness, LLC DBA CrossFit PAX may use or disclose my personal health information for the purpose of carrying out treatment, evaluating the quality of service provided, and any administrative operations related to treatment. I understand that I have the right to request restrictions, in writing, regarding how my personal health information is used and disclosed for treatment and administrative operations. I also understand that FourEight Fitness, LLC DBA CrossFit PAX will consider requests for restrictions on a case by case basis, but is not required to oblige to such requests.

I hereby authorize the licensed physical therapist providing my care to communicate with the coaches at CrossFit Pax regarding my condition and the impact of my treatment on my ability to safely participate in CrossFit classes. __________ (initials)

I do not want communication between the licensed physical therapist providing my care and the coaches at CrossFit Pax. __________ (initials)

I have read and understand the above consents, assignment of benefits, release of information, and designated individuals authorization above.

Patient Signature ____
Date____________________

Parent or Guardian Signature for patients under 18 years of age

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Date____________________