Susan Frikken, DPT, LMT
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www.yaharatherapy.com

Waiver and Consent for Treatment

Associated documents: Yahara Therapy LLC "Policy Statement" and "HIPAA Notice of Privacy Practices"

I, the undersigned, have stated all of my known health conditions and treatments on the "Confidential Health Intake" form, and realize it is solely my responsibility to keep the therapy practitioner updated on any changes in my health, diagnoses (whether professionally diagnosed or self-assessed) and treatments, as it may affect our sessions. I have consulted a preferred health care practitioner regarding conditions of concern to me.

I understand that a physical therapy diagnosis is specific to the function and mobility of the body and is not a substitute for a medical diagnosis. It has been made clear to me that I may be asked to see a medical provider for additional screening if deemed necessary, prior to beginning or resuming treatment.

By signing this release, I hereby consent to waive and release the therapist Susan E. Frikken, DPT, LMT (dba "Yahara Therapy, LLC") and any other business with which she is affiliated, from any and all liability past, present and future relating to physical therapy and to massage therapy and bodywork, except for cases of negligence on the part of the therapist.

I agree to actively participate in my own healing and health maintenance. I understand that all therapy services are strictly non-sexual. I agree that I will not undergo therapy while under the influence of alcohol or other substances that affect or alter my ability to perceive and respond to therapy safely, unless explicitly approved in writing by the prescribing medical provider.

By signing this consent, I give permission for authorized personnel of Yahara Therapy, LLC to perform all necessary procedures and treatments outlined in the plan of treatment. These treatments may include, but are not limited to, manual therapy, prescribed movement and exercise, and thermal treatments of heat or cold. By signing this consent, I agree to the intended purposes of these treatments and understand that no additional claims will be made in regard to these treatments.

When participating in a session by telephone or video, I understand that I will not be directly supervised in the same physical space, and thus my risk of injury may be higher. I will do everything that I can to perform any directed movements or treatments in the safest manner possible; I will ensure my environment is safe at all times, adjusting as needed for the duration of the session (as well as for any subsequent activities that I am prescribed and perform while not under direct supervision of the therapist). This means I may need to change my position, location, or other objects. This also means that if an environment cannot be made or found to be safe, I will report this and avoid working in that environment. I will let my therapist know if I am unable to comply fully with any of these directives, so that we may work on a solution together to make the most of my session and keep me safe. I will report any pain, concerns, confusion, or other sensations to my therapist whether I am asked or not, as this is important to understanding and ultimately improving my health and wellness.

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I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that I have certain rights to privacy regarding my protected health information. **I understand that this information can and will be used in the following circumstances:** To make telephone calls or email contact for appointment reminders and to discuss health related information; to coordinate and share information with any health care providers I am seeing regarding my treatment or to request records from them regarding my case; and to provide requested information to my insurance company or payer, if applicable. All efforts will be made to share only the information needed.

By signing this document, I agree to abide by the policies and procedures stated in the "Policy Statement" as well as that stated above. I also accept that this agreement will remain in effect until it is revoked by me in writing. I agree that a photocopy of this authorization be accepted if necessary.

I consent to receive communication and appointment reminders by email or text.

Initial to opt out of text: _____

Initial to opt out of email: _____

I agree to receive email or paper statements for any balance that I may incur.

Initial to opt out of email: _____

I have carefully read, or had read to me, all above information and am fully aware of what I am signing. I have had the opportunity to ask for more detailed explanation and don't expect Yahara Therapy LLC practitioners to anticipate and explain all possible risks and complications of treatment. I fully understand that there is no implied or stated guarantee of success for the above-mentioned treatments.

I give my permission and consent to treatment for my present condition and for any future condition(s) for which I seek treatment.

Client Name _____

Client Signature_____

Today's Date _____

Parent/Guardian Signature _____
(for Clients age 17 years or younger)

