Advanced Neurologic Rehabilitation

Informed Consent Agreement

Thank you for choosing to use the facilities, services, or programs of Advanced Neurologic Rehabilitation. We request your understanding and cooperation in maintaining both your and our safety and health by reading and signing the following informed consent agreement.

I, the undersigned, declare that I intend to use some or all of the activities, facilities, programs, and services offered by Advanced Neurologic Rehabilitation and I understand that each person, (myself included), has a different capacity for participation in such activities, facilities, programs, and services. I am aware that all activities, services, and programs offered are educational, recreational, or self- directed in nature. I assume full responsibility, during and after my participation, for my choices to use or apply, at my own risk, any portion of the information or instruction I receive.

I understand that part of the risk involved in undertaking any activity or program is relative to my own state of fitness or heath (physical, mental, or emotional) and to the awareness, care and skill with which I conduct myself in that activity or program. I acknowledge that my choice to participate in any activity, services, and program of Advanced Neurologic Rehabilitation brings with it my assumption of those risks or results stemming from this choice and the fitness, health, and awareness, care, and skill that I posses and use.

I further understand that personnel, who may not be licensed, certified, or registered instructors or professionals sometimes conduct the activities, programs, and services offered by Advanced Neurologic Rehabilitation. I accept that fact that the skills and competencies of some employees and/or volunteers will vary according to their training and experience and that no claim is made to offered assessment or treatment of any mental or physical disease or condition by those who are not duly licensed, certifier, or registered and herein employed to provide such professional services.

I recognize that by participating in the activities, facilities, programs, and services offered by Advanced Neurologic Rehabilitation, that I may experience potential health risks such as transient light-headedness, fainting, abnormal blood pressure, chest discomfort, leg cramps, and nausea and that I assume willfully those risks. I acknowledge my obligation to immediately inform the nearest supervising employee of any pain, discomfort, fatigue, or any other symptoms that I may suffer during and immediately after my participation. I understand that I may stop or delay my participation in any activity or procedure if I so desire and that I may also be requested to stop and rest by a supervising employee who observes any symptoms of distress or abnormal response.

I understand that I may ask any questions or request further explanation or information about the activities, facilities, programs, and services offered by Advanced Neurologic Rehabilitation at any time before, during, or after my participation.

I declare that I have read, understood and agree to the contents of this informed consent agreement in its entirety.

x_____/_____/_____

Patient/Responsible Party Relationship to patient **Date**

Consent for Treatment

I give this practice my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practice's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at the practice.

I understand that I have the right to request restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

x_____/_____/_____

Patient/Responsible Party Relationship to patient **Date**

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Adult Photo and Videotape Release Form

I, the undersigned, hereby consent without further consideration or compensation, to give Advanced Neurologic Rehabilitation, the absolute right and permission to use my photograph or video in its promotional materials, publicity efforts, advertisements and social media.

I hereby grant permission to Advanced Neurologic Rehabilitation to crop, screen or alter the photograph or video as necessary for use on materials produced by and on behalf of Advanced Neurologic Rehabilitation. I understand that these images may be used alone or in conjunction with other photographs or videos for educational purposes, still or moving, sketches, advertising and publication in any manner and in any medium whatsoever without limitation or reservation.

I release all claims against Advanced Neurologic Rehabilitation, their employees, agents and designees from liability for any violation of any personal or proprietary right I may have in connection with such use.

I am 18 years of age or older.

x_____ _____/_____/_____
Patient/Responsible Party Relationship to patient **Date**

Cancellation Policy

Advanced Neurologic Rehabilitation schedules a high ratio of therapists to patients. When you cannot come to your appointment it hurts 3 people: You, because you are not getting the therapy you need; other patients, because they could be scheduled during the time you did not come; and Advanced Neurologic Rehabilitation because we are professionals and this is our business. Therefore, it is imperative that if you are unable to make your scheduled appointment you provide the courtesy of a 24 hours cancellation notice, *including cancellations for illness*. Cancellations made with less than 24 hours notice will result in a $50.00 cancellation fee *per hour scheduled*. Speech therapy cancellations will also result in a $50.00 charge. If you no show to your appointment it results in a $50.00 fee, after two no shows in a treatment series, all future appointments will be cancelled, unless special arrangements are made.

If 3 appointments are cancelled with-in a treatment series all future appointments will be cancelled unless special arrangements are made.

x_____ _____/_____/_____
Patient/Responsible Party Relationship to patient **Date**