SYNERGY
HEALTH PARTNERS

CONSENT TO PARTICIPATE

☐ AURORA OFFICE	☐ THORNTON OFFICE	☐ DENVER OFFICE
14111 E. Alameda Avenue Suite 200 Aurora, CO 80012 Phone: (303) 343-1357 | Fax: (303) 343-3036	8515 Pearl Street Suite 100 Thornton, CO 80229 Phone: (303) 630-0400 | Fax: (303) 630-0405	1250 S. Sheridan Blvd. Denver, CO 80232 Phone: (303) 927-7119 | Fax: (303) 568-9331

The goals of the rehabilitation program will include:

1. Determining the cause and extent of your problem.
2. Providing a therapeutic exercise program to increase strength, endurance, range of motion, flexibility, and to decrease pain.
3. Return you to a full-duty, non-restricted work status and lifestyle.

The equipment and process of testing will be explained to you.

Your participation in the rehabilitation program is voluntary. You can stop at any point in the program. However, should you stop your program we will need to notify your doctor, insurance company, and attorney (if applicable).

If at any point during the evaluation or rehabilitation process you have any questions, we will answer them to the best of our ability or refer you to someone more qualified. Please be advised that there are no guarantees that the personal goals and/or those listed above will be met to your satisfaction. The success of any rehabilitation process lies in the combined efforts of you and your provider. The "Team" approach has the best chance of attaining your goals so please ask as many questions as are necessary for you to gain the maximum benefit from your program.

Since the process of strengthening and conditioning is a form of "controlled strain", there is a chance of aggravation or injury. It is, therefore, imperative that you communicate to your provider any aggravation or injury that you may observe during the rehabilitation process. For example, the best exercise for you, if performed too soon after your injury, may be your worst enemy. Failure to discuss any concerns or problems with your provider may lead to more problems in the future.

You will be evaluated by a physical therapist (PT) that is licensed to practice in the state of Colorado. Each treatment session may be with the PT or physical therapist assistant under the direction and supervision of the PT. Treatments may also be provided with the help of therapy aids under the direct supervision of the PT.

I, Theodore J. Angel , have read the above and understand the risks and benefits of the rehabilitation program. I agree to participate and have my rehabilitation information released to my doctor, insurance carrier, and/or attorney (if applicable).

Patient Signature: _____ Date: 03/10/2023

Parent/Guardian Signature: _____ Date: 03/10/2023
(IF PATIENT IS A MINOR)

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OPEN GYM DISCLOSURE

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I, Theodore J. Angel , understand that physical therapy occurs in an open gym setting where exercises, biomechanical training, and manual therapy occur. I accept receiving therapy services under these conditions and acknowledge my right to decline any procedure performed at any time or request a more private setting to participate in my rehabilitation program.

PHYSICAL THERAPY RECORDS

A. I understand that all physical therapy records are generated and maintained electronically. I understand that anything received via paper pertaining to my physical therapy treatments (i.e. scripts for PT or outside medical records) will be scanned in and placed into my electronic chart. I understand that my records are "backed up" in two off-site locations. I understand that all records will be maintained for at least 7 years after my date of discharge.

B. I understand that I may request copies of my records by submitting a written request to the medical records department. A records request form may be filled out with the front receptionist. I further understand that my records will be provided to me in either compact disk (CD) or paper format which may take up to 1 week to fill.

C. I understand that there will be no change in my ability to access my physical therapy records should the primary Physical Therapist die, retire, or otherwise cease to practice Physical Therapy in this office. I understand that I will continue to have access to my records through the record request form (as described above) if the unforeseen event that the primary Physical Therapist no longer works in the facility.

Patient Signature: _____ Date: 03/10/2023

Parent/Guardian Signature: _____ Date: 03/10/2023
(IF PATIENT IS A MINOR)