Functionize Health & Physical Therapy

INFORMED CONSENT AGREEMENT

Thank you for choosing to use the facilities, services, or programs of Functionize Health and Physical Therapy. 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, _____, declare that I intend to use some or all of the activities, facilities, programs, and services offered by Functionize Health and Physical Therapy and I understand that each person, myself included, has a different capacity for participating in such activities, facilities, programs, 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 health (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, service, and program of Functionize Health and Physical Therapy brings with it my assumption of those risks or results stemming from this choice and the fitness, health, awareness, care, and skill that I possess and use.

I accept the 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 offer assessment or treatment of any mental or physical disease or condition by those who are not duly licensed, certified, or registered and herein employed to provide such professional services.

I recognize that by participation in the activities, facilities, programs, and services offered by Functionize Health and Physical Therapy, 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 that 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 Functionize Health and Physical Therapy 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.

Signature _____ Date _____