



**Intake/ Consent to Treat**

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

Parent/Guardian (if <18 yrs): \_\_\_\_\_

Address: \_\_\_\_\_ City/Zip: \_\_\_\_\_

Phone (C): \_\_\_\_\_ (H): \_\_\_\_\_

Email address: \_\_\_\_\_

In case of emergency, please contact: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

**Reason for visit:** \_\_\_\_\_

I authorize Dynamic Mobility to release my medical information regarding this injury or condition to my primary care or referring provider if requested or required by law. I authorize my primary care or referring provider to send information regarding this injury or condition to Dynamic Mobility as necessary.

I authorize Dynamic Mobility to release my medical information regarding this injury or condition to: \_\_\_\_\_.

I understand that Dynamic Mobility will maintain my privacy to the highest standards and may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment, or when required to by law.

**Consent to treatment**

I consent and agree to actively participate in a physical therapy assessment and subsequent treatments, personal care and therapeutic exercises or activities prescribed by Dynamic Mobility physical therapists. I understand that physical therapy is meant to restore movement and function with as little pain or discomfort as possible and therefore understand that physical activity is an integral part of this treatment process. The physical therapist will explain the nature and purposes of the evaluation, subsequent procedures and the course of treatment. The physical therapist will inform me of expected benefits and complications as well as any discomfort, risks that may arise and any alternatives to the proposed treatment that may be applicable.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_