Patient Waiver

Patient's Name: _____
Date of Birth: _____
Phone Number: _____
Email Address: _____

Disclosure and Acknowledgment of Risks

☐ I acknowledge that I have been informed that, as with any medical practice, physical therapy may have inherent risks and potential for certain unusual physical changes during exercise or treatment. These risks can include, but are not limited to, temporary muscle soreness, strains, fractures, bruising, abnormal blood pressure changes, fainting, and, in rare instances, more serious complications like heart attack. I recognize that it is my responsibility to communicate any health problems, allergies, medications, or reasons I should not participate in a specific exercise program with my therapist.

Assumption of Risk

☐ I am fully aware that I am participating in these sessions at my own risk and, based on the information provided, I agree to cooperate fully and comply with the established plan of care. By signing this document, I expressly assume all risks and dangers, whether caused in whole or in part by the negligence of the Practice's representatives, employees, or by any other person, and accept full responsibility for any losses and/or damages that may occur.

Communication and Release of Information

☐ I authorize the release of my medical information to appropriate third parties, such as my referring physician, primary care provider, or insurance company, for the purposes of continuity of care, payment, and healthcare operations. This authorization remains in effect unless I revoke it in writing. I understand that the Practice will maintain confidentiality as required by federal law and only disclose information pertinent to my care and billing.

Waiver and Release of Liability

☐ In consideration of being allowed to participate in physical therapy activities, I hereby release, discharge, and agree not to sue Dynamic Mobility, LLC, its employees, agents, or contractors, from any and all liability, claims, demands, losses, or damages for personal injury, property damage, or wrongful death caused or alleged to be caused in whole or in part by the negligence of the Practice or otherwise.

Patient Signature: _____