RD Physical Therapy & Wellness, LLC

Tel: 443-253-4603 Fax: 410-720-2690

Clinic Location : 5070 Dorsey Hall Drive, Suite 101, Ellicott City, MD 21042

PATIENT CONSENT FORM

Name: _____ DOB: _____

Through the use of this consent form, I authorize RD Physical Therapy & Wellness, LLC to perform the followings: (Item 1 and 2 must be checked before treatment begins with the therapist)

____ 1. Request evaluation and treatment from RD Physical Therapy & Wellness, LLC

____ 2. To exchange/release personal information with those care professionals treating/practicing on site, who are directly involved in the care of myself or my dependant(s) so they may understand my/his/her medical condition and needs.

_____3. To release to (if the health care professional is not located on-site):

____ 4. To release information pertaining to an auto or personal injury accident to attorney's office, insurance agencies.

____ 5. To receive form (if the health care professional is not located on site):

_____
(Name of person, Doctors name, Organization, attorney's office, or institution-for items 3, 4 and 5.)

_____
(Address)

_____ _____
Phone# Fax#

The following Information:

____ Patient History Information
____ Medical Records
____ Education/ Academic Records
____ Psychological Evaluation
____ Neurological Evaluation
____ X-Ray's/MRI's
____ Behavioral Report
____ Teacher's Report
____ Verbal Exchange
____ Other information
_____
(State Other Reason)

I have read and understand the foregoing notice and all of my questions have been answered to my complete satisfaction in a way I can understand. I have reviewed the notice of Privacy Practice.

_____ _____
Patient's Name (Please Print) Signature of Individual
Date Signed ____/_____/_____

****RELEASE IS VALID FOR DURATION OF THE TREATMENT****