Notice & Consent to Treat

Patient: **Today's Date:**

NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt

By signing this form, you acknowledge that you have been offered a copy for review of ATI's Notice of Privacy Practices which is prominently displayed in the clinic and available on our website. This Notice of Privacy Practices provides information about how we may use and disclose your protected health information. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice and if you have any questions about our Notice of Privacy Practices, please contact our Privacy Officer at (630) 296-2222.

X_____ X_____
Patient/Guardian Signature Date

_____
Relationship to Patient

GENERAL CONSENTS AND ACKNOWLEDGEMENTS

1. I consent to and hereby authorize ATI Physical Therapy ("ATI"), through its appropriate personnel, agents and affiliates to perform the evaluation, care and treatment procedures that are deemed necessary by my physician(s) and other healthcare providers (collectively my "Care"). I understand that no warranties or guarantees have been made to me about the outcome of my Care.
2. I understand that ATI works with accredited academic institutions, through clinical affiliations, to provide healthcare professionals in training with hands-on patient care experiences and opportunities to apply learned skills to actual patient care. I further understand that such healthcare professionals in training may be involved in my Care.
3. I understand that ATI will not be responsible for the loss, destruction or theft of any of my personal property. I take full responsibility for, and release ATI from, any and all responsibility and/or liability for the loss, destruction or theft of my personal property at, or in the vicinity of, any ATI location or clinic.
4. I understand and acknowledge that ATI may lease or license real estate, equipment or other personal property (collectively "Leased Property") from third parties to perform the evaluation and treatment procedures that are deemed necessary by my physician and therapist in the treatment of my condition. In consideration of being permitted to make use of and/or have access to the Leased Property, I do hereby, on behalf of myself, on behalf of any minor or other person for whom I have requested such evaluation and treatment procedures ("Minor"), on behalf of my heirs, successors and assigns, and on behalf of such Minor's heirs, successors and assigns release and forever discharge any and all direct or beneficial owners of the Leased Property and their respective successors, related entities, directors, officers, employees, and agents (collectively, "Releasees") from, and hereby waive and release, any and all claims, demands, actions, and causes of action whatsoever arising out of or in any way related to any loss, damage, or injury, including death, that may be sustained by me and/or such Minor in, on, upon, in connection with or while making use of the Leased Property, regardless of whether any such loss, damage, or injury is caused by the active or passive negligence of the Releasees or otherwise and regardless of whether any such liability arises in tort, contract, strict liability or otherwise, to the fullest extent allowed by law. This paragraph **does not release any claims, demands, actions, and/or causes of action against ATI.**
5. I understand that I am not permitted to take pictures or make video or audio recordings at any ATI location or clinic or of my care, other patients or ATI personnel.
6. I understand that to ensure that patient inquiries are handled promptly, courteously, and accurately, some of the phone calls between ATI (or any of its affiliates, agents, assigns and service providers) and me (or anyone I have authorized to speak with ATI) may be monitored and/or recorded.
7. I understand and consent that ATI may from time to time make calls and/or send text messages to any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me and/or the account holder. I understand and consent that the manner in which these calls or text messages are made may include, but is not limited to, the use of prerecorded/artificial voice messages and/or automatic telephone dialing systems. I understand that I am not required to agree to this provision as a condition of receiving services and that my consent may be revoked at any time.
8. I understand and consent that ATI may send emails to me at any email address provided to ATI and/or use other electronic means of communication to the extent permitted by law. I understand that I am not required to agree to this provision as a condition of receiving services and that my consent may be revoked at any time.
9. I understand and acknowledge that my appointment times are scheduled in accordance with availability of professional staff. I understand that my appointment may be rescheduled by ATI if I arrive more than 15 minutes late. I also acknowledge that ATI requires 24 hours' advance notice of cancellation and that ATI reserves the right to charge a $40.00 cancellation fee if I fail to cancel an appointment at least 24 hours in advance.

X_____ X_____
Patient/Guardian Signature Date

Communication Preferences

Patient: **Today's Date:**

DIGITAL COMMUNICATION PREFERENCES

ATI Physical Therapy offers our patients exciting ways to stay connected to your treatment. Our digital services, known as ATI Connect, includes the ATI patient App and web portal, which give you easy visibility to important aspects of your treatment including progress towards your goals, access to your individualized video home exercise program, and appointment reminders, to name a few. We invite you to take advantage of this great companion to treatment!

☐ **Yes! Sign me up for ATI Connect, which includes services like the ATI App and web portal that gives me access to appointment reminders, view videos of my home exercise program, and monitor my treatment progress. I will also receive exciting information regarding ATI's products and services, which I can opt out of at any time.**

Email Address: _____

☐ **No, I do not wish to provide my email for these services at this time**

X_____ X_____
Patient/Guardian Signature Date

Consent to Communicate to Others

I hereby authorize ATI, through its appropriate personnel, to communicate with _____, my (circle one) **husband / wife / mother / father / son / daughter / significant other / friend** regarding billing and payment for services rendered on my behalf. I understand that ATI will attempt to verify the identity of those I authorize to communicate regarding billing and payment by way of seeking confirmation of the answers to at **least 2** of the following questions:

1) **Patient's mother's maiden name is _____.**
2) **City in which the patient was born _____.**
3) **Birthday of the patient is _____.**
4) **Name of patient's current pet is _____.**
5) **Zip code of the patient's mailing address is _____.**

☐ **I wish to decline authorization for others to communicate with ATI on my behalf.**

X_____ X_____
Patient/Guardian Signature Date