Susan Frikken, DPT, LMT
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Waiver and Consent

I, the undersigned, have stated all of my known health conditions and treatments on the "Confidential Health Intake" form, and realize it is solely my responsibility to keep the therapy practitioner updated on any changes in my health, diagnoses (whether professionally diagnosed or self-assessed) and treatments, as it may affect our sessions. I have consulted a primary health care practitioner regarding conditions of concern to me.

I understand that a physical therapy diagnosis is specific to the function and mobility of the body and is not a substitute for a medical diagnosis. It has been made clear to me that I may be asked to see a medical provider for additional screening if deemed necessary, prior to beginning or resuming treatment.

By signing this release, I hereby consent to waive and release the therapist Susan E. Frikken, DPT, LMT (dba "Yahara Therapy, LLC") and any other business with which she is affiliated, from any and all liability past, present and future relating to physical therapy and to massage therapy and bodywork, except for cases of negligence on the part of the therapist.

I agree to actively participate in my own healing and health maintenance. I understand that all therapy services are strictly non-sexual. I agree that I will not undergo therapy while under the influence of alcohol or other substances that affect or alter my ability to perceive and respond to therapy safely, unless explicitly approved in writing by the prescribing medical provider.

By signing this consent, I give permission for authorized personnel of Yahara Therapy, LLC to perform all necessary procedures and treatments outlined in the plan of treatment. These treatments may include, but are not limited to, manual therapy, prescribed movement and exercise, and thermal treatments of heat or cold. By signing this consent I agree to the intended purposes of these treatments and understand that no additional claims will be made in regard to these treatments.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that I have certain rights to privacy regarding my protected health information. **I understand that this information can and will be used in the following circumstances:** To make telephone calls or email contact for appointment reminders and to discuss health related information; to coordinate and share information with any health care providers I am seeing regarding my treatment or to request records from them regarding my case; and to provide requested information to my insurance company or payer, if applicable. All efforts will be made to share only the information needed.

By signing this document, I agree to abide by the policies and procedures stated in the "Policy Statement" as well as that stated above. I also accept that this agreement will remain in effect until it is revoked by me in writing. I agree that a photocopy of this authorization be accepted if necessary.

Client Name ____

Client Signature____

Today's Date _______________________________

Parent/Guardian Signature ____
(for Clients age 17 years or younger)

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