Spokane Rehab & Pain Clinic, LLC

Consent for Outpatient Treatment

Consent for Rehabilitation Treatment: The patient named below hereby voluntarily consents to the rendering of rehabilitation care at Spokane Rehab & Pain Clinic, LLC (SRPC), which will include various treatment interventions considered to be necessary for the patient's progress. An explanation will be provided to the patient of the nature and purpose of his/her rehabilitation treatment and is aware that some mild and temporary discomfort may occur during or after the treatment. The patient acknowledges that no guarantees have been made as to the result of treatment. The patient consents to other health care personnel in training being present during treatment and in some instances providing supervised treatment.

Attendance Policy: The patient has reviewed a copy of the attendance policy. I understand that it is important to attend all scheduled appointments. I understand it is my responsibility to know my appointment dates and times.

Patient Rights and Responsibilities: I acknowledge I have reviewed a copy of Spokane Rehab & Pain Clinic, LLC "Patient Rights and Responsibilities."

Patient Valuables: SRPC shall not be liable for the loss or damage to any patient personal property.

Use & Disclosure of Information About You: SRPC may use and disclose information about you and your health for the purposes of diagnosing and treating you, for obtaining payment for your care and for conducting health care operations. There are regulations that control how SRPC may use information about you and your health. SRPC abides by these regulations. These regulations are explained in more detail in the "Notice of Privacy Practices". You have the right to review the "Notice of Privacy Practices" prior to signing this document. SRPC reserves the right to make changes to its "Notice of Privacy Practices." You will not receive a revised Notice of Privacy Practices unless there are material changes. However, should you like a copy or wish to review any new revisions of SRPC's Notice of Privacy Practices you may obtain a copy at the clinic you are receiving care.

YOUR SIGNATURE BELOW ACKNOWLEDGES THAT YOU HAVE READ AND UNDERSTAND THIS DOCUMENT AND ACCEPT ITS TERMS. You are also acknowledging that you have received and/or been offered a copy of SRPC "Notice of Privacy Practices."

SRPC does not discriminate on the basis of age, sex, marital status, race, creed, color, national origin or the presence of any sensory, mental or physical handicap, sexual orientation, and/or gender identification.

The patient has read this form, and is satisfied that he/she understands its content and significance, and agrees to the terms and conditions, and/or rights and responsibilities.

_____ _____ Date___/____/____

Signature of Patient Print Name

_____ _____

Patient's Representative or Guarantor Relationship to Patient

_____

Signature of Witness