SMITH PHYSICAL THERAPY AND RUNNING ACADEMY, LLC

COMPLIMENTARY INJURY SCREEN REGISTRATION & WAIVER

DATE:		
NAME:		
DATE OF BIRTH:	**PHONE:**	
ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**
***E-MAIL:**		
EMERGENCY CONTACT:	**PHONE:**	

HOW DID YOU HEAR ABOUT SMITH PHYSICAL THERAPY AND RUNNING ACADEMY?
WHAT ARE YOU SEEKING TREATMENT FOR?
WHEN DID THE INJURY OCCUR AND/OR SYMPTOMS BEGIN?
HAVE YOU RECEIVED ANY OF THE FOLLOWING TREATMENTS FOR THE SAME CONCERN IN THE PAST? ☐ **PT:** Date ____ / ____ / _____ ☐ **Chiropractic** ☐ **Massage** ☐ **MRI:** Date ____ / ____ / _____ ☐ **X-Ray:** Date ____ / ____ / _____ ☐ **CT Scan**: Date ____ / ____ / _____ ☐ **Other (specify):**

*Providing email authorized online correspondence including newsletters, event notifications, etc.

I am requesting that a complimentary injury screening be performed by Smith Physical Therapy and Running Academy personnel. I understand and acknowledge that the purpose of an injury screen is to assess my injury and come up with a plan of action. I understand and recognize that this is a voluntary screening that may include first aid treatment and education to assess a current injury. I acknowledge that I am being evaluated by a physical therapist, occupational therapist, physical therapist assistant, occupational therapy assistant or athletic trainer and not a physician. I understand that in some states the therapist cannot perform treatment without a prescription for therapy. I understand this screening is not a substitute for medical examination, diagnosis, or a physician's care. I understand that I may receive a recommendation to see another health care provider for diagnosis and treatment. I acknowledge and agree that I am responsible for arranging and obtaining any follow up medical care or health screening.

I agree to indemnify, defend and hold harmless, Smith Physical Therapy and Running Academy and their respective officers, agents, partners, shareholders, affiliates and employees from and against any and all liability, suits, losses, costs, expenses or other claim of damage whatsoever, arising from any and all bodily or personal injuries or death created by my participation in the screening.

I have read, understand and agree to the terms of this agreement. I have been given an opportunity to ask questions and all questions have been answered to my satisfaction. I acknowledge that I am signing the agreement freely and voluntarily and intend by my signature that this be a complete and unconditional release of all liability to the greatest extent allowed by law.

Reminder: We cannot provide Complimentary Injury Screens for Medicare, Medicaid, Tricare, Veteran Affairs, Medicare Advantage, or other plans that receive federal funding.

The above information I have supplied is complete, true, and correct to the best of my knowledge.

Name of Patient or Legally Authorized Representative: _____

Signature: _____ Date: _____ /_____ / _____

Refusal of Treatment (Emergency Medical Recommendation Only): I acknowledge that immediate and/or emergent medical intervention and treatment has been recommended to me based upon the findings of a complimentary injury screening. I am refusing further medical intervention and treatment at this time. I understand the risks of refusing intervention and treatment and I accept full responsibility for what may happen because of my refusal. I release the Smith Physical Therapy and Running Academy and its employees from any liability regarding any ill effects from refusal of medical intervention and treatment.

Signature of Patient or Legally Authorized Representative: _____ Date: ___ /___ / _____

[FOR THERAPIST USE ONLY]

Subjective:

Objective:

Assessment:

Plan: