**INMOTION HEALTH, PA**

**INFORMED CONSENT FOR ASSESSMENT AND TREATMENT**

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that I am eligible to receive a range of services from InMotion Health, PA and InMotion Health, PA health care providers. The type and extent of services that I receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me. Treatment may be provided over the course of several weeks if follow up is required or deemed necessary.

I understand that I have the right to ask questions throughout the course of treatment and may request an outside consultation. (I also understand that my provider may provide me with additional information about specific treatment issues and treatment methods on an as-needed basis during the course of treatment and that I have the right to consent to or refuse such treatment. I understand that I can expect regular review of treatment to determine whether treatment goals are being met. I agree to be actively involved in the treatment and in the review process. No promises have been made as to the results of this treatment or of any procedures utilized within it. I further understand that I may stop treatment at any time, but agree to discuss this decision first with InMotion Health, PA and InMotion Health, PA health care providers.

**Maintaining Results**:

For continued results, you may require additional Medical Treatments at intervals determined by your treatment provider in conjunction with your personal treatment plan.

*I have read and understand I may require future treatment to maintain results*. Initials:\_\_\_\_\_\_\_\_

**Financial Responsibility**:

I understand the regular charge applies to all subsequent treatments. I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I further agree in the event of non-payment, to bear the cost of collection and/or Court costs, fees and reasonable legal fees, should this be required.

*I have read and understand I am financially responsible for services rendered*. Initials:\_\_\_\_\_\_

**Disclosure of Health History/Medications/Substance Abuse Use**:

I agree to inform the staff of any known allergies to medications, foods and/or other substances and have disclosed any previous allergic reactions. I further agree to inform staff of any/all medications/substances I am currently taking, including recreational or street drugs, and have disclosed all pertinent health history. I understand that failing to inform the staff about my medical issues and/or drug use can lead to serious complications.

*I have disclosed all medication, allergy, and health history to staff*. Initials:\_\_\_\_\_\_\_

**Consent**:

By signing below, I acknowledge and agree:

* I have fully disclosed on my Patient Intake Form any medications, previous complications, planned or previous surgeries, sensitivities, allergies, or current conditions that may affect my treatment.
* I have read the foregoing informed consent for Medical Treatment and agree to the treatment with its associated risks.
* I acknowledge that no guarantee has been given by anyone as to the results that may be obtained.
* I have received and will follow all aftercare instructions as it is crucial to do so for good healing and to minimize the risk of complications.
* I hereby consent to perform this, and all subsequent Medical Treatments, with the above understood. I hereby release the the health care provider performing Medical Treatment, and INMOTION HEALTH, PA and its staff from liability associated with this procedure.
* It has been explained to me in a way that I understand:
	+ The above treatment or procedure undertaken.
	+ There may be alternative procedures or methods of treatment.
	+ There are risks, known and unknown, to the procedure or treatment proposed.
* **IF I AM SIGNING ON BEHALF OF A MINOR CHILD, I ALSO GIVE FULL PERMISSION FOR ANY PERSON CONNECTED WITH INMOTION HEALTH, PA, TO ADMINISTER FIRST AID DEEMED NECESSARY, AND IN CASE OF SERIOUS ILLNESS OR INJURY, I GIVE PERMISSION TO CALL FOR MEDICAL AND/OR SURGICAL CARE FOR THE CHILD AND TO TRANSPORT THE CHILD TO A MEDICAL FACILITY DEEMED NECESSARY FOR THE WELL BEING OF THE CHILD.**

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Patient Name (Print) Patient Signature Date

**IF PARTICIPANT IF UNDER THE AGE OF 18:**

Signature of Parent or Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_; Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Guadian/Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT ACKNOWLEDGEMENT AND RELEASE**

**Treatment Liability Waiver**

I acknowledge that Medical Treatment(s) may or may not mitigate, alleviate, or cure the condition for which it has been prescribed. Medical Treatment(s) has been recommended to you in the belief that it is of potential benefit in these circumstances and its use will quite probably improve the conditions for which you are under treatment and in your overall health.

The risks involved and the possibilities of complications have been explained to me. I fully understand and confirm that the nature and purpose of the aforementioned Medical Treatment(s) to be provided and fully agree to submit to the Medical Treatment.

Therefore, in consideration for any treatment received, I agree to unconditionally defend, hold harmless and release from any and all liability the company and the individual that provided my treatment, the insured, and any additional insured’s, as well as any officers, directors, independent contractors, or employees of INMOTION HEALTH, PA, for any condition or result, known or unknown, that may arise as a consequence of any treatment I may receive.

I understand and agree that any legal action of any kind related to any treatment I received will be limited to binding arbitration pursuant to the Arbitration Agreement.

By signing below, I acknowledge and agree:

I have carefully read the information on this Consent Form and understand I may be giving up some important legal rights by signing.

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Patient Name (Print) Patient Signature Date

Signature of Parent or Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Guardian/Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INMOTION HEALTH, PA**

**Lab and Imaging Consent Form**

* Consent for Treatment and Payment:

This is to certify that I consent to and authorize InMotion Health, PA and InMotion Health, PA health care providers to perform specimen collection and analysis of the recommended laboratory tests. I understand, consent to and authorize InMotion Health, PA and InMotion Health, PA health care providers to order any necessary laboratory tests or imaging tests from third party CLIA laboratories or imaging centers. I understand that InMotion Health, PA health care providers, will order, read, and interpret the results. In the given case that abnormal lab values or abnormal imaging results are found, I will be referred to my PCP or a specialist for further treatment and management as deemed necessary. I understand that I have the sole responsibility to take appropriate action on the laboratory and imaging results and consult my PCP/specialist regarding abnormal results. I also agree to take full financial responsibility for the cost of the tests that I request and authorize to be ordered by InMotion Health, PA and InMotion Health, PA health care providers. I also agree to and authorize InMotion Health, PA and InMotion Health, PA health care providers to share my insurance information and medical information, if needed, with a third party certified CLIA Lab or imaging centers.

I understand that I am fully responsible for the fees associated with obtaining specimens, lab costs, imaging costs, ordering, reading and interpreting the labs and imaging by InMotion Health, PA and InMotion Health, PA health care providers. This fee will be given prior to the service being provided. You will access your labs via your patient portal with InMotion Health, PA or through well-known laboratory/imaging companies that will be working with InMotion Health, PA, portals. If a result is deemed “critical”, InMotion Health, PA and InMotion Health, PA health care providers will make every attempt to contact you.

* I have read this form - or had it read and explained to me - in full. I fully understand its content.
* I have been given opportunity to ask questions, and any questions have been answered to my satisfaction.

I hereby give my informed consent to provide specimens for lab testing and fully accept the fees associated with obtaining specimens, lab costs, imaging costs, ordering, reading and interpreting the labs and imaging by InMotion Health, PA and InMotion Health, PA health care providers. I also agree to and authorize InMotion Health, PA and InMotion Health, PA health care providers to share my insurance information and medical information, if needed, with a third party certified CLIA Lab or imaging centers.

By signing below, I acknowledge and agree:

I have carefully read the information on this Lab and Imaging Consent Form.

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Patient Name (Print) Patient Signature Date