Carolina Therapeutics

Consent to Treat

I, _____ (patient/parent/guardian), knowing that _____ (patient full name) has a diagnosis requiring therapeutic treatment, hereby voluntarily consent to such care and treatment for the aforementioned patient by Carolina Therapeutics, PLLC as may be beneficial in the professional judgment of the patient's therapist(s) and primary care physician. I am aware that no guarantee has been made as to the effect or efficacy of therapeutic intervention treatment with the named patient.

I am aware that gross motor activities are often encouraged during therapy and that swinging, running, climbing, jumping and other gross motor activities can be used to assist with a variety of skills and performance components the therapist may need to address. I consent to the use of gross motor activities and exempt my loved one, therapist(s), clinician(s), and owner(s) of Carolina Therapeutics, PLLC, from any injury or liability resulting from this type of play.

I am aware that other persons not listed on the patient's prescription may be in the same therapy room during treatment, especially if therapy is provided in-home, at a daycare/preschool setting, or within the community setting. Carolina Therapeutics, PLLC, its clinicians, or owners, are not responsible for any accident or injury that occurs during treatment and I expressly absolve them from any liability for any such accident or injury that occurs during treatment.

The named patient has my permission to participate in a natural environment and clinical setting during therapy sessions. I understand that this presumes the presence of a wide variety of other people including but not limited to, other children, siblings, parents, professionals, volunteers, or students. The named patient may participate in therapy in the home, school, clinic, and community as discussed by the clinician, patient, and persons involved in the patient's treatment plan in order to maximize carryover of functional skills.

Each therapist will assign various activities for patients to participate in to maximize the carryover of functional skills as part of the patient's Home Exercise Plan (HEP). I have been notified that compliance with the HEP is necessary and required in order to continue receiving therapy services, and my insurance and other medical professionals may be notified of my participation, or lack thereof, with the HEP.

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I agree that any and all legal claims made against Carolina Therapeutics, PLLC or Carolina Therapeutics Academy, LLC, its therapists, and its affiliated companies, are to be decided by binding arbitration pursuant to the rules of the American Arbitration Association utilizing the laws of the State of North Carolina. I agree to pay all costs associated with binding arbitration, in addition to the attorney's fees of Carolina Therapeutics, PLLC, in the event my legal claims are unsuccessful.

Acknowledgement
I, _____ (patient, parent, legal guardian), have read and understand the policies stated above, and I agree to the terms as stated.
Signature:
Date: