**General Informed Consent to Care**

TO THE PATIENT: You have a right to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make a decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved.

This consent form is simply an effort to obtain your permission to perform an evaluation necessary and to identify the appropriate treatment and/or procedure for any identified condition(s). This consent provides us with your permission to perform any reasonable and necessary medical examinations, testing and treatment.

**By signing below, you are indicating that:**
**(1) you intend that this consent is continuing in nature even after a specific current diagnosis has been made and treatment recommended; and**
**(2) you consent to treatment at this office and/or any other place of service, of your choice during concierge or telehealth visits. This consent for live and telehealth appointments will remain fully effective until it is revoked in writing.**
**(3) you consent to telehealth services (if appropriate) that occur via live audio and/or video on a HIPPA compliant platform (potential privacy risks may still exist, so please turn on privacy/encryption mode when using).**

You have the right at any time to discontinue services and to discuss your treatment plan with your Physical Therapist or Physician about the purpose, potential risks and benefits of any test or treatment ordered and performed for you. If you have any concerns regarding anything recommended by your healthcare provider, we encourage you to ask questions.

I voluntarily consent to treatment with FIT PARSONS and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Signature of Patient or Patient Representative | Date

_____ _____

Printed Name of Patient or Patient Representative | Relationship to Patient