

I, the undersigned have stated my known health conditions and treatments on the “Confidential Health Intake” form. I understand it is my responsibility to keep the OT practitioner updated on any changes to my health, diagnoses, procedures and treatments as they may affect our sessions. I understand if I have a procedure it is my responsibility to consult with the clinicians involved to determine pre-cautions, restrictions or the go ahead to continue with OT therapy sessions. I have consulted a primary health care practitioner regarding conditions of concern to me.

Permission for screening, assessment and treatment. I give permission to the professional staff to perform tests and assessments deemed appropriate for my health plan. I understand that the services I receive are provided by an Occupational Therapist licensed in the State of Wisconsin and include assessments of my body as they relate to movement and daily function. The services are holistically focused, include neuromuscular re-education, therapeutic exercise, relaxation, and wellness as they pertain to activities of daily living. Occupational Therapy treatment encompasses suggestions and education on lifestyle, stress, work, career, exercise, emotions, spiritual and intellectual well being. I agree to be responsible for my choices and do what feels right for me and my goals. I understand that I may be asked to see a medical provider for additional screening if deemed necessary, prior to beginning or resuming treatment.

The Therapeutic Process

I understand that the assessments and treatment by InnerSparks,Ilc is in regard to movement and function and is not a substitute for a medical diagnosis of my health conditions. I understand that the OT programs are geared towards facilitating healthy living to restore balance and wellness. If I have any concerns about my health and participation in the program, I agree to discuss my concerns with my provider as well as seek further medical advice. By signing this release, I hereby consent to waive and release the therapist, Andrea Legatt Carvin, OTR/L (dba InnerSparks,Ilc Rehab Gym & Spa) and any other business with which she is affiliated, from any and all liability past, present and future relating to occupational therapy, wellness, and lifestyle coaching.

Client Agreement

I also agree to actively participate in my own health and health maintenance. The movements you are about to learn are intended to gently enhance the way your body moves and your overall health. If you have any concerns about your medications or diet, as they relate to movement including blood pressure, chronic pain or other conditions, or health please check with your physician before participating in this program. In addition, please respect your own body. If any movement or instruction does not feel right to you, please do not do it. Ask for a modification of a movement or exercise. Exercise is not without its risks and this or any other exercise program may result in injury. To reduce the risk of injury, consult your physician prior to beginning this exercise program. As with any exercise program, if at any point, you begin to feel faint, dizzy, or have physical discomfort, you should stop immediately and consult a physician.

Telehealth or Video Sessions

I understand that I will not be directly supervised in the same physical space and my risk of injury may be higher. I will do everything that I can to perform any directed movement or treatments in the safest manner possible; I will ensure my environment is safe at all times, adjusting as needed for the duration of the sessions (as well as for any subsequent activities that I am prescribed and perform while not under direct supervision of the therapist). This means I may need to change my position, location and objects in my environment. This also means that if an environment cannot be made or found to be safe, I will report this and avoid working in that environment. I will let my therapist know if I am unable to comply fully with any of these conditions, so that we may work on a solution together to make the most of my session and keep me safe. I will report any pain, concerns, confusion, or other sensations to my therapist whether I am asked or not, as this is important to improving my health and wellness.



WAIVER AND CONSENT 2020 (CONTINUED...)

Release of Information: InnerSparks, llc does not disclose client information unless specifically requested by the client to the extent allowed by law. (HIPPA,1996) I understand that this information can and will be used in the following circumstances: To make telephone calls or email contact for appointment reminders, to discuss health related information; to coordinate and share information with any health care providers I am seeing regarding my treatment, or to request records from them regarding my case; and to provide requested information to my insurance company or payer when applicable. All efforts will be made to share only the information needed.

Informed consent: The potential benefits, risks, and alternative treatment options for my condition and the range of services InnerSparks, llc, Rehab Gym & Spa offers has been explained to me. I agree to abide by the policies stated above. I also accept the agreement will remain in effect until it is revoked by me in writing. I agree that a photocopy of this authorization also can be accepted.

Please sign:

Signature _____ Date _____

Name Typed _____