



# Head to Toe

PHYSICAL THERAPY

## Release Of Information

I authorize Head to Toe Physical Therapy to release information regarding my care to those companies/individuals listed below unless otherwise indicated. This information may be in the form of typed or written notes, faxed information, billing information, or verbal discussions. (Please note: Number 1-4 is required if billing your physical therapy treatments to your insurance company.)

1. My referring physician
2. My primary care physician (if different)
3. My insurance carrier
4. My attorney's office (Name): \_\_\_\_\_
5. Others: \_\_\_\_\_  
\_\_\_\_\_

I authorize Head to Toe Physical Therapy to discuss my scheduling of appointments with the following individuals:

Name: _____	Relationship: _____
Name: _____	Relationship: _____
Name: _____	Relationship: _____

## Fitness Facility Waiver

I am aware that exercise can be physically stressful and in rare instances can even be harmful. I am also aware that anyone who smokes, has ever had elevated blood pressure, is over 40 (male) or 50 (female) years of age, presently does not exercise, has ever had cardiac (heart) problems, is overweight, has diabetes, has any other cardiovascular problems or is susceptible to orthopedic problems is more at risk while exercising.

I understand that my participation in treatment at Head to Toe Physical Therapy and the use of the Health Club and Spa's facilities are voluntary and at my own risk. I hereby release Head to Toe Physical Therapy, the Health Club and Spa, and any of their affiliates, agents, assigns, employees and representatives, from and hold them harmless against any liability arising out of my participation.

I have read this form and have had the opportunity to ask questions. I have sufficient information to give my informed consent to participate in the exercise program.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_