EXAMINATION AND TREATMENT CONSENT

I ______________________________ consent to an examination and treatment
Print Name

provided after an explanation of the procedures is offered. I understand that the examination and/or treatment may elicit discomfort of any existing conditions that I may have.

I (**circle one**) DO / DO NOT permit Rainbow Rehab, LLC to use the results of my treatment in clinical studies and clinical education as long as my identity is not disclosed.

I (**circle one**) DO / DO NOT permit photographs and/or videos to be taken while under treatment for the purpose of clinical education and/or clinical studies.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law (HIPAA Privacy Rule), we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

______________________________ ______________
Patient's Signature Date

______________________________ ______________
Guardian or Power of Attorney Signature Date

Patient Name (print) ______________________________

______________________________ ______________
Patient's / Guardian's Signature Date