Rebecca Nash, DPT
323.574.7000
drrebeccanash@gmail.com

INFORMED CONSENT FOR TREATMENT

I am aware of my diagnosis and agree to receive treatment at Rebecca Nash, DPT. I permit Rebecca Nash, DPT to render interventions judged to benefit me. I understand that this care can include an evaluation, testing, and treatment.
During the course of your care, additional services may be recommended to you. These recommendations will be based on objective findings and/or the clinical expertise of the associate you are seeing. Upon receiving such recommendations, please be advised that you reserve the right to:
1. Decline the recommendations
2. Accept the recommendations
2. Accept the recommendations, and request collaboration with other providers

If at any time during the course of your care with Rebecca Nash, DPT you are not achieving your goals I will immediately re-assess your case, revise your plan of care as necessary, or refer you to another provider.
I also recognize that you retain the right to choose what services you will receive, where you will receive them, and from whom.

I give permission to Rebecca Nash, DPT to release information, verbal, and written, contained in my medical record, and other related information to my insurance company, related healthcare provider, assignees, and /or beneficiaries and all other related persons as it relates to my treatment.

I authorize Rebecca Nash, DPT to obtain medical records and /or professional information from my physician or other medical professional as it relates to my treatment.

Patient Signature/Date: _____