Bare Necessities
Physical Therapy

Pain/Injury Evaluation

A "Pain/Injury Evaluation" from Bare Necessities is a brief appraisal that will take up to 15 minutes.

Informed Consent

1. I ____________________________________ (write in your name) acknowledge and understand that Tony Bare DPT (Doctor of Physical Therapy, "therapist") located at 7853 Scarborough Dr., Colorado Springs, CO 80920 (clinic) will perform an injury assessment.
2. I also recognize that the physical therapy pain/injury evaluation may involve the touching of the injured area by the therapist and that partial disrobing may be required to facilitate such care, all of which is expressly consented by me. (You can refuse any and all requests or recommendations).
3. I have read the above and certify that I have had the opportunity to discuss the contents thereof to my satisfaction. By signing below, I hereby consent to the physical therapy pain/injury evaluation by the therapist.

Signature:______________________________ Date: ________________

Parent/Guardian:_________________________ Date:________________

Patient Name:_______________________ Age:__________ DOB:________

Address:____

Phone Number: ____________________ Cell:____________________

Patient Authorization
Patient Name: ___________________________ **Date of Birth:____________**

Release of Information & Consent for Treatment
All information provided herein is true and correct.

I am aware of my diagnosis and wish to receive treatment at ACB, LLC, DBA Bare Necessities Body and Soul Physical Therapy (Bare Necessities). I permit its owner/therapist to treat me in ways they judge are beneficial to me. I consent to the rehabilitation and related services at this clinic. I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching and/or direct contact of a sensitive nature. I understand that this care can include an evaluation, testing and treatment. No guarantees have been made to me about the outcome of this care.

I give permission to Bare Necessities to release my information, verbal and written, contained in my medical record and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related health care provider, assignees and/or beneficiaries and all other related persons as it related to my treatment and/or payment for services provided.

I authorize Bare Necessities to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.

The signature below certifies that I have read and understand the above information. **Initial**: _________

Notice of Privacy Practices (HIPAA Acknowledgement/Consent)
I hereby acknowledge that I have received a copy o The Notice of Privacy Practices for Bare Necessities.
In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and health care operations.

Payment Guarantee
I agree to pay Bare Necessities for the services provided to me or the party named above. Payment will be in the form of cash, check or credit card. If using a credit card an additional 2% fee will be added to cover the cost of card processing.
Payment is due at the time of service.
Receipts can be provided upon request for patient insurance filing or health savings account payment. **Initial**: _________

Patient or Guardian Signature: _______________________________
Date:________________