POSITIONAL RELEASE THERAPY INSTITUTE

Patient Assumption of Risk and Informed Consent

I, _____, of _____
(Patient – Please Print) (Address of Patient)

Acknowledge, declare and agree as follows:

1. That I have been informed that there may be dangers, hazards and potential complications inherent to receiving an evaluation and treatment involving the medical or orthopedic condition associated with my current condition. I personally recognize and appreciate that such dangers, hazards and potential complications exist. Such dangers, hazards and potential complications may include but not be limited to: aggravation of current symptoms, including soreness, additional pain, increased numbness or potential temporary or permanent nerve injury. While I am participating in the evaluation process and therapy or treatment provided by the Positional Release Therapy Institute, I understand and accept that the evaluation process and the therapy administered may result in soreness, additional pain, increased numbness or potential temporary or permanent nerve injury. I agree to indemnify and hold harmless the Positional Release Therapy Institute, its employees and agents, from and against any and all claims, demands, actions or causes of action related to personal injury, or death, which may occur or result directly or indirectly from my participation in the evaluation process and therapy administered (either at the time of evaluation or when therapy is administered or any time thereafter) and not as a direct result of any gross negligent act of the Positional Release Therapy Institute, its employees or agents. That I have voluntarily agreed to participate in an evaluation and therapy program provided by the Positional Release Therapy Institute on the day of_____and month of _____, during the year of 20___. In consideration of being permitted to participate in this Program, I voluntarily assume the risks discussed previously and execute this "Release and Assumption of Risk and Informed Consent" on my behalf on myself, my heirs and next-of-kin, my personal representatives and my estate.
2. That I have been fully informed of the nature, scope and demands of the orthopedic evaluation and therapy program, its potential benefits, risks, and alternatives along with prognosis with and without, and I understand that the applied and/or recommended therapy program may include other similar activities (e.g., physical exercise), which could be dangerous to me. If you are concerned that your condition may limit your ability to participate in your evaluation and therapy, you will need to consult your physician prior to receiving an evaluation, therapy or treatment at our facility.
3. I declare that I am able physically to withstand and cope with the indicated rigors of the evaluation process and therapy program, with or without accommodation.
4. I request that this "Release and Assumption of Risk and Informed Consent" be construed and interpreted pursuant to the laws of the State of Utah, and if any portion thereof is held invalid, I request the remainder continue in full force and effect.
5. I understand that acceptance of this "Release and Assumption of Risk and Informed Consent" by the Positional Release Therapy Institute shall not constitute a waiver in whole or in part sovereign immunity by the Positional Release Therapy Institute, its employees or agents.
6. I hereby certify that I am covered by an accident and health insurance policy which will be in effect at any and all times that I am participating in orthopedic evaluation process and therapy program related activities.
7. **This document covers your initial evaluation, treatment, therapy or any thereafter related to your condition.**

I declare that I completely understand and have fully informed myself of the terms and conditions of this "Release and Assumption of Risk and Informed Consent" by having read it, or having it read to me, before signing. I understand that this "Release and Assumption of Risk and Informed Consent" shall be effective for a period of three years from this date. Assented and agreed to on this ____ day of _____, 20___.

_____ _____
Print Name (Patient/Client) Signature

_____ _____
Name of Guardian on behalf of minor Signature