Participant:

DIGI Rehab USA, LLC

Notice & Consent to Treat

Today's Date:

NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt

By signing this form, you acknowledge that you have been offered a copy for review of the Notice of Privacy Practices of DigiRehab USA, LLC, which is prominently displayed on our website. This Notice of Privacy Practices provides information about how we may use and disclose your protected health information. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice and, if you have any questions about our Notice of Privacy Practices, please contact our Privacy Officer at info@digirehab.us.

X _____ X _____

Participant/Guardian Signature — Date

_____

Relationship to Participant

GENERAL CONSENTS AND ACKNOWLEDGEMENTS

1. I consent to and hereby authorize DigiRehab USA, LLC (DR-US), through its personnel, agents and affiliates to perform the evaluation, care and treatment procedures that are deemed necessary by my physician(s), therapists and other healthcare providers (collectively my "Care"). I understand that no warranties or guarantees have been made to me about the outcome of my Care.
2. I understand that DR-US works with DigiRehab World, A/S (DR-World), physical therapy business entity located in the nation of Denmark, to assist in the evaluation, assessment and reassessment of each Participant's ability to perform physical exercise, their likelihood of improving their physical ability, and to prescribe specific exercise routines. I consent to DR-US providing my protected health information (PHI) to DR-World for these purposes.
3. I understand that I am not permitted to take pictures or make video or audio recordings at any DR-US location or clinic or of my care, other patients or DR-US personnel.
4. I understand that some of phone calls, text messages and other electronic communication between DR-US (or any of its affiliates, agents, assigns and service providers) and me (or anyone I have authorized to communicate with DR-US) may be monitored, transmitted electronically and/or recorded.
5. I understand and consent that DR-US may from time to time make calls and/or send text messages to any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me and/or the account holder. I understand and consent that the manner in which these calls or text messages are made may include, but is not limited to, the use of prerecorded/artificial voice messages and/or automatic telephone dialing systems. I understand that I am not required to agree to this provision as a condition of receiving services and that my consent may be revoked at any time.
6. I understand and consent that DR-US may send emails to me at any email address provided to DR-US and/or use other electronic means of communication to the extent permitted by law. I understand that I am not required to agree to this provision as a condition of receiving services and that my consent may be revoked at any time.

X _____ X _____

Patient/Guardian Signature — Date

Communication Preferences

Patient: **Today's Date:**

Consent to Communicate to Others

I hereby authorize DR-US, through its appropriate personnel, to communicate with _____ , my (circle one) **husband / wife / mother / father / son / daughter / significant other / friend** regarding billing and payment for services rendered on my behalf. I understand that DR-US will attempt to verify the identity of those I authorize to communicate regarding billing and payment by way of seeking confirmation of the answers to at **least 2** of the following questions:

1) **Patient's mother's maiden name is _____.**

2) **City in which the patient was born _____.**

3) **Birthday of the patient is _____.**

4) **Name of patient's current pet is _____.**

5) **Zip code of the patient's mailing address is _____.**

☐ **I wish to decline authorization for others to communicate with DR-US on my behalf.**

X_____ X_____
Patient/Guardian Signature Date

_____

Relationship to Patient