INFORMED CONSENT FOR ACL INJURY RISK ASSESSMENT

I have been informed by Modern Sports Physical Therapy that the ACL Injury Risk Assessment is a risk assessment for potential future injury. This assessment is a screening evaluation based on injury history, current sports practices/participation, and physical assessment only. The ACL Injury Risk Assessment does not replace or supersede your routine health care provider.

The physical therapist has fully explained to me the nature and purposes of the procedures and assessment. It has been explained to me that during the course of the assessment, unforeseen conditions may be revealed that necessitate recommendations for additional evaluations.

I understand that no guarantees or assurances have been made nor can be made by Modern Sports Physical Therapy as to the results of the recommendations made from the assessment.

I affirm that I am, or my child is, in good physical condition and do(es) not suffer from any disability, impairment or ailment that would prevent or limit my, or my child’s, participation in this screening or the recommended corrective exercises.

I understand that all physical activity comes with a certain degree of risk and I fully accept the risk associated with engaging in any recommended exercises.

I have been given an opportunity to ask questions, and all my questions have been answered to my satisfaction.

I have carefully read the above and fully understand this consent form

Signature of patient/guardian:_______________________________________ Date:_____________
## MEDICAL HISTORY

Please list any medical conditions you currently have or have had

List any medications you are currently taking

List any surgeries you have had (include dates)

## ATHLETIC INFORMATION

List all the sports you play, positions you play, how many teams you play for & timeframe for each team

List any injuries you have had or are currently dealing with (sprains, strains, etc.)

Briefly describe your current weight-training program

Tell me anything else that you think might be helpful for me to know
Cancellation & No-Show Policy

As a courtesy to others, our therapists, and other patients, Modern Sports Physical Therapy, PLLC requires at least a 24-hour notice for cancellation. A $150 fee will be billed if this policy is violated.

If you do not show up for your appointment (considered a “no-show”), you will be billed $150.

I fully understand the cancellation & no-show policy

Signature of patient/guardian:_______________________________________ Date:__________

Photography & Video Consent & Release Form

Photography and video recordings of my assessments help get the word out about what I do, how I can help people, and helps me educate others. Please read below and sign if you give your consent to allow me to record/photograph any part of your assessment. Refusal to consent to photographs and/or videos will in no way affect the medical care you will receive.

I consent for medical photographs and/or videos to be made of me or my child (or person for whom I am legal guardian). I understand that the photography, audio or video recordings may be used for the following purposes:

- Teaching purposes (informational/educational presentations or courses)
- Educational videos
- Medical publications (journals, textbooks, online/offline electronic publications)

There is no time limit on the validity of this release nor is there any geographic limitation on where these materials may be distributed.

I hereby grant permission to the rights of my image, likeness, and sound of my voice as recorded on audio or video tape without payment or any other consideration. I understand that my image may be edited, copied, exhibited, published, or distributed and waive the right to inspect or approve the finished product wherein my likeness appears. I also waive any right to royalties or other compensation arising or related to the use of my image or recording. I understand this permission signifies that photographic or video recordings of me may be electronically displayed via the internet or in the public educational setting.

I have carefully read and fully understand the above release.

Print Name:__________________________________________________

Signature of patient:____________________________________________ Date:__________

If under the age of 18, then the signature of the patient’s parent or legal guardian is required

Signature of parent/guardian:____________________________________ Date:__________