Idaho State University

Consent for Participation

I, _____, give permission for the faculty and students of Idaho State University (ISU), Physical Therapy Clinic to use information gathered from my participation for educational training and research. I understand that services furnished in the Student Led Pro Bono Physical Therapy Clinic are not covered by the Medicare program. All services provided in the Student Clinic are furnished by ISU Physical Therapy students under the supervision of instructors who are qualified physical therapists.

Please initial each of the statements after you have read them. By initialing and signing you are indicating that you have read and understand the provisions and information.

_____ I acknowledge that I meet or am below the income level requirements and have provided the required information to the clinic staff.

_____ I acknowledge that I do not have any form of Medicare, Medicaid or health insurance or have maxed out my yearly Physical Therapy benefit.

_____ I acknowledge that I am 18 years of age or older at the time of treatment.

_____ I understand that if I miss 2 or more sessions without giving the clinic a 24 hour notice, I will be discharged from this program and placed on the waiting list.

I understand that I may have recently completed therapy under a certified plan of care with another Physical Therapist. Even if the prior therapist has concluded that I have completed the course of therapy under that Plan of Care, I would like to continue working with ISU's physical therapy students on the skills I have learned, to improve my general welfare, and to support the training mission of ISU.

While participating in the Pro Bono Student Clinic, students will provide periodic evaluations under the supervision of their instructors, as part of their training. The practice of medicine is not an exact science and no guarantees have been made regarding the results of the care or treatment. If you experience any new or concerning symptoms at any time, you will be encouraged to seek follow up care from your primary healthcare provider or at a local emergency care provider.

By providing my telephone number I consent that ISU its employees, volunteers or agents may contact me by telephone, or message service regarding my appointments. I understand that I can withdraw my participation at any time during this experience. I can revoke my permission to use the information pertaining to my case by contacting ISU's HIPAA Compliance Officer at (208) 239-4380.

I acknowledge that I have received or been offered a copy of this document, the clinic's Notice of Privacy Practices. I acknowledge that I have read and fully understand and agree to all of the above provisions and information in this document and I consent fully and voluntarily.

_____ _____

Printed Name *Date*

_____

Signature