



Athens Regional Rehabilitation Center

Patient Summary List

List known significant medical diagnoses / conditions **(include history of cancer)**:

List known significant operative / invasive procedures **(include pacemaker or any metal implants from prior surgeries)**: _____

List known adverse and allergic drug reactions: _____

List known medications to be prescribed for and/or used by patient: _____

My goals for therapy include: _____

I, _____, give my consent for the Physical Therapy Department of Athens Regional Medical Center to provide physical therapy as ordered by my physician. I have been informed of my treatments and plan of care and hereby give consent for treatment. I understand that it is my responsibility to inform the physical therapy department of my complete medical history and to keep them informed of any changes in my medical condition and/or medication regimen to ensure continuity of care. Failure to do so could result in an inappropriate treatment program.

I understand that cancellations and "no shows" interfere with the rehabilitation team's ability to be productive and to serve all their patients. I understand that cancellations also will hinder my progress in therapy. If I have **two** "no shows" without contacting the department, I will be discharged and my physician will be contacted regarding my noncompliance.

Patient Signature

Date