



**INFORMED CONSENT FOR TREATMENT  
AND AGREEMENT TO COMPLY  
WITH PROGRAM**

I agree that the therapist at Morris Hospital Rehab Services has discussed my proposed therapy program. The purpose, procedures, and goals including possible outcomes and risks, benefits, and alternatives of treatment in accordance with my physician's orders have been discussed.

I hereby acknowledge an informed consent to treatment and the program. I understand that my participation in the treatment program is vital to my progress and recovery. Lack of follow through at home may hinder/slow results.

- I acknowledge that family members or significant others may be included in my recovery process as necessary.  
**YES or NO**
- Which family member/friend may we speak with about your therapy?

**Name (s)** \_\_\_\_\_

**Your therapist may contact you if you miss your appointment.**

- What number is best to contact you (circle best option)

**Home #** \_\_\_\_\_

**Cell #** \_\_\_\_\_

**Work #** \_\_\_\_\_

- May a message be left on your voicemail if we cannot get a hold of you?  
**YES or NO**
- May a message be given to another person (other than you) who answers the phone?  
**YES or NO**
- May we contact you by phone about appointment reminders?  
**YES or NO**

**A member of our Rehab Service team will contact you within a few weeks of your last therapy session to answer any questions and follow up with your recovery.**

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Signature of Legal Guardian

\_\_\_\_\_  
Signature of Therapist, credentials

\_\_\_\_\_  
Date

Patient Label