Tel: (718)676-4112

Fax: (718)676-4134

2952 Brighton 3rd Street, Brooklyn NY 11235

https://primefitnessphysicaltherapy.com
evaynshtok@yahoo.com

Photography Consent Form

Prime Fitness Physical Therapy is proud to announce that we offer the Schroth Method as a treatment approach to management of scoliosis, kyphosis, and other postural conditions in both adolescents and adults of all ages. The treatment is a form of Physiotherapeutic Scoliosis-Specific Exercise, or PSSE, a non-surgical treatment method. Elena Vaynshtok MSPT, DPT, CKPT, a certified physical therapist (C1 Level) has undergone additional extensive training and certification program through the Barcelona Scoliosis Physical Therapy School in order to perform this treatment. Our ultimate goal would be is to integrate this optimal alignment of the 3-D posture that you have learned into your activities of daily living. As a means of documenting the treatment progress, we will take pictures of your physical form before and after treatment. **Your face will be concealed.**

Check here if patient is a minor (under 18 years old) or unable to provide consent

I consent for medical photographs to be made of me or my child (or person for whom I am a legal guardian). I understand that this information may be used in my medical record, for purposes of medical teaching, or for publication in medical textbooks or journals as I have designated below. By consenting to these medical photographs, I understand that I will not receive payment from any party. **I also understand that if I refuse to consent to photographs for the Schroth Method for treatment, I will not receive this conservative (non-surgical) treatment method for scoliosis, kyphosis and other postural related issues.**

Please select one box from the following

I consent for my images to be released to members of the media or to be used by Prime Fitness Physical Therapy for the purposes of website and social media (Facebook, Instagram, Twitter, etc.), news media (online, print and/or broadcast), medical and/or educational training, closed circuit television programs, as well as in medical publications, including medical journals, textbooks, and electronic publications and for advertising purposes. I understand that the images may be seen by members of the general public, in addition to scientists and medical researchers that regularly use these publications in their professional education. Although these photographs will be used without identifying information such as my name, I understand that it is possible for someone to recognize me. I also agree for my image to be shown for teaching purposes and to be used for my medical record.

OR

I consent for my images to be used in medical publications, including medical journals, textbooks, and electronic publications and for advertising purposes. I understand that the images may be seen by members of the general public, in addition to scientists and medical researchers that regularly use these publications in their professional education. Although these photographs will be used without identifying information such as my name, I understand that it is possible for someone to recognize me. I also agree for my image to be shown for teaching purposes and to be used for my medical record.

OR

I consent for my images to be shown for teaching purposes AND to be used for my medical record, but NOT for medical publications.

OR

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I consent for my images to be for my medical record ONLY.

This authorization shall remain in effect for 12 months from the date indicated below and will renew annually automatically. You can change your consent or revoke this authorization in writing by sending a **written** request to Prime Fitness Physical Therapy, 2952 Brighton 3rd Street, Brooklyn NY 11235.

By signing this consent, I confirm that this consent form has been explained to me in terms which I understand.

Printed Patient Name	Signed Patient Name	Date

If completed by patient's personal representative, please print name and sign below.

Printed Representative Name	Patient Representative Signature	Date

Relationship to Patient

Printed Employee Witness Name	Employee Witness Signature	Date