Consent for Treatment – Physical Therapy

Acct #:_____ **Date:**_____

CORE Provider:_____

For office use only

Patient Name: _____ Date of Birth: _____

Physical Therapy is a patient care service provided in response to a wide range of medical care needs of outpatients of all ages.

The purpose of Physical Therapy is:

- To treat disease, injury and disability by evaluation, examination, testing and use of rehabilitative procedures, manipulations, massage, exercise and physical agents including, but not limited to, mechanical devices, heat, cold, electricity and ultrasound in the aid of diagnosis or treatment
- To obtain for the physician information needed in diagnosis and evaluations of patients
- To prevent or minimize residual physical injury or disability
- To aid the patient in achieving maximum potential within his or her capabilities
- To accelerate convalescence and reduce the length of the functional recovery

All procedures will be thoroughly explained to you before they will be performed.

There are certain inherent risks with Physical Therapy treatment because you will be asked to exert effort and perform activities with increasing degrees of difficulty. It is possible that this could cause an increase in your current level of pain or discomfort or an aggravation to your existing injury. There is also a possibility that you could experience a new injury. If any activity causes you to feel increased pain or discomfort, stop the activity and notify your therapist. This will help reduce the risk of injury or aggravation of your condition(s). The Physical Therapist and/or Physical Therapist's Assistant will take care to ensure that you are protected from any hazardous situation. You will never be forced to perform any procedure that you do not wish to perform.

Based on the above information I agree to cooperate fully and to participate in all Physical Therapy procedures and to comply with the plan of care as it is established.

In the process of deciding where to attend my Physical Therapy, I was given the opportunity to make my own choice and direct where I would like to have my services completed.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Last Revision Date: 3.16.2019