TRUE NORTH PELVIC PT PATIENT CONSENT

Treatment Conset

I agree and give consent for physical therapy treatment. I request and authorize the performance of rehabilitation procedures as permitted by the New Hampshire Physical Therapy Practice Act and as deemed necessary by my physical therapist.

Pelvic Floor Treatment informed consent (if applicable)

I understand that it may be advisable to have an internal pelvic floor examination. Examination may include assessment of skin condition, strength, and scar mobility. Treatment may include palpation and the use of internal and external soft tissue and joint mobilization techniques. I have the option of having a second person in the room. The second person can be a friend or family member. Potential risks may include an increase in the level of pain or aggravation of an injury. This is usually temporary and if it does not subside in 1-3 days, I agree to contact my PT. Potential benefits may include an improvement in my symptoms and a greater knowledge about management of my symptoms. I will let my therapist know if I am pregnant, have an IUD, am less than 6 weeks post-partum/post-surgical, and if I have a sensitivity to latex or lubricants. Please initial I agree: _____ I do not agree: _____Not applicable: _____

Release of Information

I agree and give consent that True North Pelvic PT may provide information from my medical record to persons involved in my medical care.

I authorize the release of medical information necessary to obtain payment of any benefits available to me to True North Pelvic PT for services rendered.

I agree that True North Pelvic PT may obtain information from others who have provided medical care to me and/or are responsible for the payment of all or part of my bills when this information is needed in order to treat, bill, and/or receive payment.

I have read “Notice of Privacy Practices” mandated by HIPPA.

Patient Agreement

I agree to pay True North Pelvic PT charges for services rendered to me during my course of treatment. I agree to pay those charges that are my responsibility.

I have informed my PT of any condition that would limit my ability to be evaluated and treated. I hereby request and consent that the evaluation and treatment to be provided.

Patient Name (please print): _____

Patient Signature: _____Date: _____

Witness Signature: _____Date: _____