**CONDITIONS & CONSENT FOR PHYSICAL THERAPY**

I acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor dysfunction. Pelvic floor dysfunctions include, but are not limited to, urinary or fecal incontinence, difficulty with bowel or bladder functions, dyspareunia (pain with intercourse), painful scars after childbirth or surgery, and persistent sacroiliac or low back or coccyx (tailbone) pain.

**Evaluation:** I understand that to evaluate my condition it may be necessary, initially and periodically, to have my therapist perform an internal pelvic floor muscle examination. This examination is performed by observing and/or palpating the perineal region including the vagina and/or rectum. This evaluation will assess skin condition, reflexes, muscle tone, length, strength, endurance, scar mobility and function of the pelvic floor region. Evaluation may include vaginal or rectal sensors for muscle biofeedback.

**Treatment:** Treatment may include, but not be limited to: observation, palpation, vaginal/ rectal dilators, vaginal weights, vaginal or rectal sensors for biofeedback, stretching and strengthening exercises, soft tissue mobilization, joint mobilization, and educational instruction.

**Cooperation with treatment:** In order for physical therapy treatment to be effective, I must come to the scheduled appointments. I understand and agree to cooperate with and perform the home physical therapy program intended for me. If I have trouble with any part of my treatment program, I will discuss it with my therapist. I understand that I can terminate care at any time. I understand that I am responsible for immediately telling the therapist if I feel uncomfortable for any reason or should I experience any pain or unusual symptoms during the evaluation/ treatment.

- I understand that I always I have the option of having a third person present in the room during the evaluation or treatment sessions.

**Informed consent for treatment:** The term “informed consent” means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to you. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition.

- Potential risks: I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury or condition. This discomfort is usually temporary. If it does not subside in 24 hours I agree to contact my physical therapist.
- Potential benefits: There may be an improvement in my symptoms and an increase in my ability to perform daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

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- Alternatives: If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

**No warranty:** I understand that there are no guarantees regarding a cure for or improvement in my condition. I understand that my physical therapist will outline and discuss goals of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

**Notice of Privacy Practices:**
I have been provided with a Notice of Privacy Practices and have had the opportunity to ask questions related to the use of my personal health information. ____ (**Initial**)

**Release of medical records:** I authorize the release of my medical records to the following physicians/primary care provider or insurance company:

| Name:<br>Address: | Name:<br>Address: |
|---|---|

**I have read the above information and I consent to physical therapy evaluation and treatment.**

- I choose to bring someone with as a third person present/ DECLINE to have a third person present (please circle one). _______ (**Initial**)

Print Name of Client:________________________________ Date:_________________________

Client or Guardian's Signature:____________________________________________________________

Therapist's Signature:________________________________ Date:_________________________