

HOLISTIC PHYSICAL THERAPY & WELLNESS

INFORMED CONSENT FOR PHYSICAL THERAPY SERVICES

Physical therapy is a patient care service that is provided in order to manage a wide variety of conditions. Services are provided to individuals of all ages regardless of gender, color, ethnicity, creed, national origin or disability. The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis and intervention by use of rehabilitative procedures, mobilization, massage, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them.

Response to physical therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. Holistic Physical Therapy & Wellness cannot guarantee what your reaction will be to a specific treatment, nor can it guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury.

Please note the following patient rights:

1. It is your right to decline any part of your treatment at any time before or during treatment should you feel any discomfort or pain or have other unresolved concerns.
2. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results.
3. It is your right to discuss the potential risks and benefits involved in your treatment.

By signing below, I agree that I have read this consent form and understand the risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care. I authorize the release of my medical information to appropriate third parties.

Initial here if you consent to photography and videography of yourself for postural analysis and to video exercises and functional body mechanics learned in your therapy sessions.

Patient Name*: _____

Signature*: _____

Date*: _____

Witness Name*: _____

Signature*: _____ Date*: _____