Informed Consent for Initial Evaluation/Physical Therapy Treatment

I understand that I will be informed of the treatment plan, the modalities and exercises, goals, length of treatment sessions, and projected number of sessions as well as my rehabilitation potential. I, or my legal guardian, fully understand that no guarantee or assurance has been made concerning the results of physical therapy treatment, which may or may not be obtained. I understand that I may withdraw my consent for treatment at anytime verbally or in writing. I understand that if I am not satisfied with the initial evaluation, I may state so, following the evaluation and leave the clinic without further obligation. However, if I choose to stay and receive treatment, I understand that I will be responsible for all fees for services rendered. I further understand that if I exercise the option to leave the clinic, the clinical director has the option of discontinuing services for myself or for this patient and the right to refuse treatment in the future for myself or this patient. I understand that payment for services is due on the day the services are provided. All co-pays must be paid on the day that services are provided and it is illegal to waive co-pays or deductibles.

Patient Name: _____ **Signature:** _____ **Date:**_____

Guardian Name:_____ Signature: _____ Date:_____

To Be Signed After Completion of the Initial Evaluation: Informed Consent

I, _____ have been informed of the results of my initial evaluation and hereby consent to the treatment as discussed by my physical therapist including application of modalities and hands on treatment as needed, which may include but not limited to all of the following: ice, heat, ultrasound, laser, electrical stimulation, traction, paraffin, and physical therapy, soft tissue and joint mobilization/manipulation, therapeutic exercises, including stretching and strengthening, postural and activities of daily living, education, pain management, education, balance, testing, and retraining.

I have had my questions answered and feel comfortable with my course of treatment. I understand that by signing this form I am authorizing treatment and am financially responsible for the initial evaluation and all treatment fees.

Patient Name: _____ **Signature:** _____ **Date:**_____

Guardian Name:_____ Signature: _____ Date:_____

Physical Therapist _____ Signature _____ Date: _____