Body Wise Therapy, P.C.
2504 South 119th Street
Omaha, NE 68144-2975

Phone: (402) 932-8686
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PATIENT INFORMED CONSENT

I hereby indicate my wish to participate in the treatment program offered by BodyWise Therapy, PC. I verify that my participation is fully voluntary and no coercion of any sort has been used to obtain my participation.

I understand that the purpose of this program is to enhance my overall health and well-being. Treatment may include manual hands on bodywork, exercises, and posture retraining and balance activities provided by a licensed physical therapist. I understand that Myofascial Release will not cause injury but I may experince soreness following exercises, stretching and manual techniques done to muscle and connective tissue. I understand, as with all Physical Therapy and medical treatment, there is the possibility of unusual reactions or changes. These may include but are not limited to muscle spasm, joint strain, bruising, fractures, lightheadedness, dizziness or tiredness. Other Physical Therapy interventions may be used during the course of treatment and the risks and benefits of those interventions will be reviewed with me at that time. I understand I may decline the use any interventions offered.

I have read the above information and understand it fully. Questions concerning these procedures have been answered to my satisfaction. I understand that I am free to deny answering any questions during the evaluation process or to withdraw from the program at any time. The information that is obtained from this process is confidential and will not be discussed with anyone other than my physician.

Signature of Patient (or responsible party)

_____

If patient is a minor, relationship of person signing consent

_____

Date

_____