INFORMED CONSENT FOR ASSESSMENT & TREATMENT

☐INTEGRATED FUNCTIONAL THERAPY ☐MEDICAL ACUPUNCTURE

I _____, understand that my assessment and treatment at Petra Health Collective is provided by Aris Georgilas and may include, but is not limited to, the following components under the umbrella of Integrated Functional Therapy (IFT):

- Exercise prescription, Manual therapy techniques (e.g., mobilizations, Massage Therapy, soft tissue release, myofascial release, Osteopathic Manual Therapy, and therapeutic stretching)
- Therapeutic modalities such as heat, ice, therapeutic taping, and cupping
- Medical Acupuncture / Electro-acupuncture / Dry Needling, involving the insertion of sterile, single-use needles into specific tissues and structures

IFT is an interdisciplinary therapeutic approach rooted in functional assessment, applied anatomy, and treatment execution. The goal is to restore function, reduce pain, improve mobility, and enhance quality of life through personalized, evidence-informed care.

Purpose and Goals:

I understand that the primary objectives of my treatment are to reduce dysfunction and pain, improve mobility, strength, and endurance, and enhance my overall functional ability and quality of life.

Potential Risks and Side Effects:

While treatment is generally safe, I acknowledge the possibility of minor risks or side effects, which include but are not limited to:

- Manual Therapy & Myofascial Release: Joint and/or muscle soreness, mild bruising
- Exercise Therapy: Temporary soreness or fatigue
- Therapeutic Taping & TENS Machine: Skin irritation, redness, or rash
- Electro-Acupuncture / Acupuncture / Dry Needling: Minor bleeding, bruising, fainting, nausea, headache, infection, and (rarely) perforation of internal organs or stimulation of labour in pregnancy

I understand that my practitioner will make clinical decisions in my best interest, and that while all efforts will be made to minimize risks, no treatment is without potential complications.

Communication and Consent

I affirm that I will notify my practitioner of any changes to my medical history, including pregnancy. I understand I will have the opportunity to discuss the nature, purpose, and expected outcomes of all treatment procedures and that I may ask questions at any time. I acknowledge that I may withdraw my consent and discontinue treatment at any time, without prejudice. I consent to assessment and treatment of the following areas, if clinically indicated: breast, chest wall, gluteal region, and upper inner thigh. These areas will only be treated with clear communication and appropriate draping to ensure comfort and privacy. This consent applies to all current and future care provided by Petra Health Collective under the scope of Integrated Functional Therapy. Clients are responsible for selecting the scope of services they wish to approach and specifying the type of receipt they require, whether for Massage Therapy, Acupuncture, or Osteopathy services. Billing will reflect the service designation chosen by the client, ensuring accurate documentation for insurance or personal purposes. I understand that my health records may be shared with other health providers within my circle of care, in accordance with Petra Health Collective's Privacy Policy. (Please ask to view the policy if you would like more information.)

_____ _____ _____

Patient/ Guardian name **Signature** **Date**