Informed Consent to Physical Therapy Evaluation and Treatment

I hearby consent to evaluation and/or treatment of my condition by a licensed physical therapist employed by Move Well LLC.

The physical therapist has fully explained to me the nature and purposes of the procedures, evaluation, and course of treatment.

The physical therapist has informed me of expected benefits, possible complications, or discomfort, which may result from skilled physical therapy care. In addition, the physical therapist has explained to me the risks of receiving no treatment.

I meant 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 a reasonable time. I agreed to contact my physical therapist.

I may experience an improvement in my symptoms and/or 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.

The physical therapist has explained that there is no guarantee that the proposed course of treatment will improve my condition and then it is plausible, although unlikely, that the course of treatment may cause additional pain or discomfort or aggravate my condition.

In order for physical therapy treatment to be effective, I must come to scheduled appointments unless there are unusual circumstances. I understand and agree to cooperate with and perform the physical therapy program intended for me. If I have trouble with any part of my treatment, I will discuss it with my therapist.

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

I’ve been given an opportunity to ask questions, and all my questions have been answered to satisfaction. I confirm that I have read and fully understand this consent form. In the event of a change in medical status, I understand that my treatment may be modified, stopped, or I may be referred out to the appropriate practitioner. I reserve the right to withdraw at any time.

I understand that Move well LLC will maintain my privacy to the highest standards I may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of services provided in any administrative operations related to treatment payment.

Patient or Patient's Guardian, signature

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Relationship to signer (self)

_____

I agree to terms listed and all information provided is accurate.

Yes / No

If there is anything you think we need to know, please include it below.

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