NAME _____ DOB _____DATE _____

INFORMED CONSENT FOR TREATMENT

The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to me. The therapists provide a wide range of services and I understand that I will receive information at the initial visit and throughout my therapy sessions concerning the treatment options available for my condition. Restore Your Core Physical Therapy is a hands-on physical therapy clinic and treatment consists primarily of manual therapy techniques. Forms of deep tissue therapy, myofascial release, bone and soft tissue manipulation, visceral manipulation, craniosacral modalities, neuromuscular re-education, therapeutic exercise, gait training, electrical stimulation, biofeedback, as well as other treatment modalities may be used. Some of the manual therapy techniques require deep pressure which may cause bruising and periods of soreness from 1-72 hours after treatment. Symptoms can also change and move to other areas of the body. Please ask if you have any questions or concerns. The number of treatments needed and recovery time will vary due to the age of the injury, number of times injured, age of the patient, overall health of the patient, and many other contributing factors.

Please read and initial beside each item:

_____I understand that I have the right to decline any portion of my treatment at any time before or during my session.

_____I understand that I may have another person in the room for any or all of my evaluation and treatment.

_____I understand that I am consenting to physical therapy performed by a licensed physical therapist, which may include internal pelvic evaluation of the muscles, organs, ligaments, and fascial structures.

_____ I acknowledge that I have the opportunity to ask questions and that all questions and concerns may be addressed to my satisfaction.

_____ I understand that treatment procedures involve both risks and benefits as indicated above.

I consent to physical therapy evaluation and treatment. I authorize Amy Robinson, PT, CLT, PRPC, WHNC and the fully trained staff to use treatment techniques as deemed necessary for my complete recovery. By initialing above and signing below, I acknowledge that I have read, fully understand and will abide by the policies noted on this consent form.

I have read and fully understand the above written statements.

X_____Date_____

Signature of patient/legal guardian (2081415v2)