Informed Consent for Treatment

The term "informed consent" means that the potential risks, benefits, and alternatives of therapy evaluation and treatment have been explained to you. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the evaluation, treatment and options available for my condition. I also acknowledge and understand that I have been referred for evaluation and treatment of general orthopedic, spinal and/or pelvic floor dysfunction. Pelvic floor dysfunctions include, but are not limited to, urinary or fecal incontinence, difficulty with bowel, bladder or sexual functions, painful scars after childbirth or surgery, persistent sacroiliac or low back pain, or pelvic pain conditions.

I will be clear in providing my evaluating physical therapist all information regarding my past medical history, past surgical history, medications, injections and procedures previously done that will assist in putting together a comprehensive physical therapy plan.

This evaluation may assess skin condition, reflexes, muscle tone, length, strength and endurance, scar mobility and function. Such evaluation may include vaginal or rectal sensors for muscle biofeedback. Treatment may include, but not be limited to the following: observation, palpation, manual soft tissue techniques, joint mobilization, use of vaginal weights, vaginal or rectal sensors for biofeedback and/or electrical stimulation, ultrasound, heat, cold, stretching and strengthening exercises, and educational instruction.

Potential Risks: I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury. This discomfort is usually temporary, if it does not subside in 1-3 days; I agree to contact my therapist.

Potential Benefits: Include an improvement in my symptoms and an increase in my ability to perform my 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.

Cooperation with Treatment: I understand that in order for therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from attending therapy. I agree to cooperate with and carry out the home program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

Alternatives: If I do not wish to participate in the physical therapy program, I will discuss my medical, surgical, or pharmacological alternatives with my physician or primary care provider. I have the right to refuse physical therapy treatment at any time and will discuss this decision with my physical therapist and referring physician.

Release of Medical Records: I authorize New Dimensions Physical Therapy to release any and all or my medical records to any parties requesting information such as, and including, any physician and/or healthcare professional involved in my care, nay insurance company from which I am seeking to receive payment for medical bills, my legal representative, and any other party or parties requesting my medical records via subpoena or court order.

Consent to Treatment of a Minor Child: I hereby attest that I am the legal custodian of the minor child names below and authorize the staff of New Dimensions Physical Therapy to administer care as they deem necessary to my: (circle one)

Name of Minor Child:_____ Relationship:_____

No Warranty: I understand that the physical therapist cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my therapist will share with me her opinions regarding potential results of physical therapy treatment for my condition. I understand that my therapist will share with me her opinions regarding potential results of physical therapy treatment for my condition and will discuss all treatment options with me before I consent to treatment.

Cancellation Policy: New Dimensions Physical Therapy requires each patient to cancel their appointment 48 hours in advance. Failure to give appropriate notice will subject the patient to a $100.00 charge, not payable by the patient's insurance. Last minute cancellation will be allowed for 2 visits:

A. Sick call
B. Emergency situation
C. At the discretion of the facility

I have:	Active Cancer	Yes	No
	Pacemaker	Yes	No
	Contagious Skin Lesions	Yes	No

I herby request and consent to the evaluation and treatment to be provided by the physical therapists of New Dimensions Physical Therapy.

Date:_____ Patient Name:_____
(Please Print)

_____ _____
Patient Signature Signature of Parent or Guardian (If applicable)