



CONDITIONS & CONSENT FOR PHYSICAL THERAPY

1. COOPERATION WITH TREATMENT:

I understand that in order for physical therapy to be effective, I must come as scheduled unless there is unusual circumstance that prevents me from attending therapy.

I understand that I may be discharged from physical therapy if I do not keep three (3) appointments without calling to cancel or reschedule.

I agree to cooperate with the home program assigned to me. If I have difficulty, I will discuss it with my therapist.

2. NO WARRANTY:

The physical therapy department does not promise a cure for my condition. The staff will share with me the available statistics and studies regarding results of physical therapy treatment for my condition. They will discuss all treatment options with me.

3. INFORMED CONSENT TO TREATMENT:

The term "informed consent" means that the potential risks, benefits and alternatives of physical therapy treatment have been explained to you. The department provides a wide scope of services and you will receive information at the initial visit on the treatment/assessment options available for your condition.

Potential Risks:

You may experience an increase in your current level of pain or discomfort, or an aggravation of your existing injury. This discomfort is temporary and will probably subside in 24 hours.

Potential Benefits:

Benefits include an improvement in your symptoms and an increase in your ability to perform your daily activities. You may experience increased strength, awareness, flexibility and endurance in your movements. You may experience decreased pain and discomfort. You will have greater knowledge on managing your condition and the resources available to you.

Alternatives:

All physical therapy treatment options available for your conditions will be explained to you. You may inquire on the cost of these services and discuss them with your therapist. If you do not wish to participate in the therapy program, you may discuss your medical, surgical or pharmacological alternatives with your physician.

4. CONSENT TO HIV TESTING:

In the event anyone in our staff should become exposed to fluids, which may transmit the HIV virus during your care, in accordance with section 32.1-37.2 of the Virginia Code, you will be deemed to have consented to the practice the right to draw blood for testing of the HIV virus, as well as to the release of such results to our practice and to the individual who suffered the exposure.

I have read or had read to me the foregoing and any questions, which may have occurred to me, have been answered to my satisfaction. I understand the risks, benefits and alternatives of the treatment. Based on the information I have received from the therapist, I voluntarily consent to physical therapy treatment. I understand that I may withdraw at anytime.

Patient's Signature/Date

Therapist's Signature/Date

Patient's Legal Representative/Guardian/Parent

Relationship to Patient