INFORMED CONSENT for PHYSIOTHERAPY

Patient Name: _____ DOB: _____

1. I understand my therapist will discuss treatment options with me and my treatment plan may include education, various forms of manual therapy techniques such as mobilization, manipulation, soft tissue release and stretches, and active exercise. Treatments may also include modalities such as heat, ice, and therapeutic taping.

2. I understand that there may be risks if I do not disclose my full health history. I understand that my therapist will educate me on the acceptable pain levels, expectations and management during my care/recovery.

3. I understand that there are very small possibilities of risks or complications that may result from the above listed treatments. I do not expect the Physiotherapist to anticipate all the possible risks and complications. Potential small but possible risk factors:

   Manual therapy: Joint and/or muscle soreness
   Exercise therapy: Joint and/or muscle soreness
   Therapeutic Taping: Minor skin irritations such as redness or rash
   Heat therapy: Burns, pain, spread infection if one is present
   Ice therapy: Temporary numbness, tingling, redness or irritation of the skin. Rare frost bite and/or nerve damage

4. I understand that the primary goals of Physiotherapy treatments are to help reduce my pain and improve my mobility, strength, endurance, function and quality of life.

5. I understand that my progress will be monitored throughout my treatment and that I will have reassessments as indicated.

6. I understand that based on my response, my goals and my reassessment findings that my treatment may be altered accordingly.

7. **I understand not complying with my prescribed treatment plan may cause, no change in my signs or symptoms, delayed recovery and/or not achieving my goals.**

8. I understand that alternative therapies (i.e., Massage Therapy, Chiropractic) or products (bracing, taping) may be warranted for my case. The corresponding health care provider will be responsible for explaining the benefits and risks.

9. I understand that many factors play a role in achieving full recovery. I may not fully achieve my initial goals and my expectations for recovery may need to be adjusted. My therapist will review the typical recovery timelines with me; however, variances may occur depending on individual circumstances.

10. I understand that I may withdraw my consent at any time. This consent will apply to my treatment going forward.

I, undersigned, do hereby give my voluntary consent for the administration of Physiotherapy deemed appropriate by my treating Physiotherapist.

_____ _____

Signature (Patient or Guardian) Date

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Name (Guardian if patient under the age of 18)