TOTAL BALANCE THERAPY
PHYSICAL THERAPY, PELVIC HEALTH, PILATES

CONDITIONS & CONSENT FOR PHYSICAL THERAPY

COOPERATION WITH TREATMENT:

I understand that in order for physical therapy treatment to be effective, I must come to scheduled appointments unless there are unusual circumstances that prevent me from attending therapy. I understand and agree to cooperate with and perform the home physical therapy program intended for me.

INFORMED CONSENT FOR TREATMENT:

The term "informed consent" means that the potential risks, benefits and alternatives of physical therapy treatment have been explained to you. The purpose of physical therapy is to treat disease, injury, and disability by examination, evaluation, diagnosis, prognosis, and intervention by use of rehabilitative procedures including but not limited to mobilization, massage, exercises, and physical agents to aid the patient in achieving their maximum potential for functional recovery within their capabilities. All procedures will be thoroughly explained to you before you are asked to perform them.

The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition.

Potential risks: You may experience an increase in your current level of pain or discomfort, or an aggravation of your existing injury or condition. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my physical therapist.

Potential benefits: May include an improvement in your symptoms and an increase in your ability to perform 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 about managing your condition and the resources available to you.

Alternatives: All physical therapy treatment options available to your conditions will be explained to you. You may inquire about 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 primary care physician.

I have read the above information and I consent to physical therapy evaluation and treatment. I have asked any questions and they have been answered to my satisfaction. I understand the risks, benefits and alternatives to treatment. I hereby voluntarily consent to physical therapy treatment. I understand that I may choose to discontinue treatment at any time.

_____	_____
Patient Printed Name	Guardian Signature (if applicable)
_____	_____
Patient Signature	Date