HEIDEN ORTHOPEDICS

Physical Therapy Informed Consent

At Heiden Orthopedics we are committed to providing you with the best possible physical therapy care. The following policies allow us to provide optimal care for all of our patients.

Physical therapy treatment is intended to result in improvement of your symptoms and an increase in your ability to perform daily activities. It is hoped that as a result of physical therapy treatment, you may experience increased strength, flexibility, endurance and body awareness, in addition to decreased pain and discomfort.

Potential Risks & Limitations:

I understand that while it is expected that the physical therapy treatment I receive will be beneficial to me, there is a risk of harm involved in physical therapy treatment, and I accept such risk in the hope of obtaining beneficial results from such services. I understand that I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury or condition. No promises of any particular outcome or successful result have been made to me, and I understand that there is some uncertainty involved in the physical therapy services for which this consent is given.

Informed Consent to Physical Therapy Treatment:

I, _____, give consent to physical therapy services provided at Heiden Orthopedics to provide and perform physical therapy testing and services as deemed appropriate for my condition. I understand that there are no guarantees regarding a cure for or improvement in my condition. This consent applies to my initial visit and all subsequent visits. I understand that this consent may be revoked in writing at any time.

Other Care & My Responsibilities:

I understand that the physical therapy services I am requesting are one component of a range of healthcare choices. I also understand that I should discuss my condition with my primary care physician or specialist. I am responsible for the following: (1) to try to understand and follow instructions about my care and ask questions if I don't understand; (2) to provide correct and complete information about my health problems and medical history, including recent treatment and medications I may receive from other health care providers; and, (3) to accept responsibility for consequences following the decision to refuse treatment or instructions.

I have read and understand all the above terms. I understand the risks, benefits, and alternatives to treatment. Based on this information, I voluntarily consent to physical therapy treatment. I understand that I may discontinue treatment at anytime.

Print Name of Patient: _____ **Date:** _____

Signature of Patient/Guardian: _____ **Date:** _____