



## Informed Consent Document for Physical Therapy Treatment

**IT IS IMPORTANT THAT YOU THE PATIENT, READ THIS CONSENT FORM CAREFULLY AND OBTAIN ANSWERS TO ANY QUESTIONS YOU MAY HAVE.**

Thank you for choosing GLACIER PEAKS MOBILE PHYSICAL THERAPY, LLC (hereinafter referred to as GPMPT) as your physical therapy and wellness provider. All treatment procedures will be performed by a doctor of physical therapy and will be fully explained during the physical therapy or wellness session. GPMPT is fully licensed and GPMPT's providing Physical Therapists are appropriately trained GPMPT Physical Therapists will endeavor to provide physical therapy that is safe, appropriate and indicated for your condition.

GPMPT will evaluate your physical therapy needs as a patient and then use a variety of procedures and treatments in an effort to improve your physical function. As with all forms of medical treatment, there are both benefits and risks involved with physical therapy. As you discuss particular risks associated with the procedures and treatments recommended for you, it is vitally important you understand those risks and ask your Physical Therapist any questions you may have. It is your obligation to provide full disclosure of your past medical history that may impact, influence or contraindicate the prescribed service provided by GPMPT.

As patient responses to specific forms of treatment can widely vary from patient to patient, it is not always possible to predict patient responses or outcomes. Therefore, GPMPT cannot guarantee any result or probability of success of any therapy or treatment procedure provided to you. **There is a risk that your therapy or treatment procedure may result in pain injury or may aggravate a pre-existing medical condition.**

You have the right to an informed discussion regarding the form of therapy or treatment procedures recommended for you based on your medical history, diagnosis(es) symptoms and the results of diagnostic testing. Your Physical Therapist stands ready to answer any questions you may have regarding a proposed course of treatment, types of physical therapy exercises, the risks they present and possible alternatives, including choosing not to participate in the physical therapy or treatment procedures recommended. Additionally, you have the right to stop or decline any portion of any physical therapy or treatment procedure during your physical therapy session.

By signing this Informed Consent Document, you are agreeing that you have discussed the risks and possible benefits of specific therapy or treatment procedures recommended for you, possible alternative procedures or treatments, and that you are agreeing to proceed with the physical therapy or treatment procedures as recommended with full knowledge and a clear understanding of the risks reasonably associated with those physical therapy procedures or treatments.

By signing this Informed Consent Document, you are further agreeing to receive additional specialized services including but not limited to wellness and/or training programs as requested by yourself or your authorized legal representative.

By signing this Informed Consent Document, you are further agreeing to and authorizing your Physical Therapist to perform additional physical therapy procedures or treatments which are determined to be necessary in the course of treatment you have previously consented to, as dictated by your injury, illness or condition.

## **Consent for Care of Patient**

Patient Name (Print) \_\_\_\_\_

GPMTP has recommended the following physical therapy or other services for this Patient including: therapeutic exercise, gait training, neuromuscular re-education, manual therapy, return to sport training.

The risks reasonably associated with the recommended physical therapy include, but are not limited to the following risks, each of which have been discussed with the Patient:

Muscle/joint soreness, pain, swelling/edema, re-aggravation of current or pre-existing condition, elevated blood pressure and heart rate.

**I CERTIFY THAT I HAVE COMPLETELY AND TRUTHFULLY DISCLOSED: MY MEDICAL HISTORY; MY COMPLAINTS, SYMPTOMS AND/OR AILMENTS; AND MY USE OF ALL PRESCRIPTION AND NON-PRESCRIPTION DRUGS, VITAMINS AND/OR DIETARY SUPPLEMENTS.**

Although my Physical Therapist has discussed specific risks with me, I understand that there is ALWAYS THE POTENTIAL FOR UNFORESEEN INJURY OR ACCIDENT TO OCCUR. Should such unforeseen injury or accident occur, I agree I will not seek to hold GPMPT liable or at fault in any way.

**I HAVE CAREFULLY READ AND FULLY UNDERSTAND THIS CONSENT FORM AND I VOLUNTARILY AUTHORIZE AND CONSENT TO THE PROPOSED PLAN FOR PHYSICAL THERAPY SERVICES:**

Patient Signature \_\_\_\_\_

Date (Day/Month/Year) \_\_\_\_\_

Name of Authorized Legal Representative of Patient (If Applicable)

Name (Print) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

