Physiotherapy Consent Form

Dear Patient:

Physiotherapy involves many different types of physical evaluation and treatment. As with all forms of medical treatment, there are benefits and risks involved in physiotherapy. The physical response to treatment varies and cannot always be predicted as every individual is different. Your recovery is our priority but we cannot guarantee outcomes and there is a risk that treatment could cause some discomfort or aggravation of the existing condition.

During your physiotherapy visit, it is often necessary to expose and touch the area in need of treatment. Every effort is made to preserve modesty and keep you comfortable. Please communicate to your therapist if you have any concerns during the treatment.

By signing this form, I hereby consent to the rendering of physiotherapy evaluation and treatment as deemed appropriate by the treating therapist. I have the right to decline treatment at any time. The therapist will explain your physiotherapy diagnosis and discuss treatment recommendations with you. Physiotherapy is most effective if you participate according to the treatment plan agreed upon with your therapist. If at any time you have questions regarding treatment and services provided, please do not hesitate to talk to your therapist.

☐**I understand** that the service fees may not be covered or may exceed my insurance plan or claim benefits and I am financially responsible for the entire cost of any unpaid claims. If your insurance company allows us to bill and receive payment directly, a doctor's referral may be needed before we can direct bill. Consent to contact your insurance company for verification of details is implied with your signature. If you qualify, would you like to use direct payment? *Yes* / *No*

☐**I understand** that all services at Physiotherapy Active Rehab are by appointment only. Failure to cancel an appointment without giving at least 24 hours' notice before your appointment will incur a fee of 50% of your treatment cost.

☐**I authorize** the release of all necessary information to my primary care provider and/or referring physician.

☐I have read this form and agree to all the consent regarding physiotherapy evaluation and treatment.

Patient Name (please print)	Patient Signature	Date