Lifestyle Physical Therapy, Inc.
Consent to Treatment

Physical Therapy is a service provided to patients of all ages regardless of sex, age, gender identity, color, race, creed, national origin, or disability in health activities. The purpose of physical therapy is to treat injury and disability by evaluation and use of rehabilitative procedures, mobilization, massage, exercises and physical agents to aid the patient in achieving their maximum potential within their capabilities. All procedures will be thoroughly explained to you before you are asked to perform them.

You are expected to cooperate fully with the evaluation and treatment program. Because of the nature of services provided you might be asked to disrobe. Your privacy, modesty, and dignity will be considered at all times by the staff. Should you feel uncomfortable or embarrassed, you may refuse the procedure, stop the procedure and/or request another therapist.

There are certain inherent risks with physical therapy because you will be asked to physically exert yourself and perform activities with increasing degrees of difficulty which could cause an increase in your current level of pain or an aggravation of your existing injury. Your physical therapist will take every precaution to ensure that you are protected from any potentially hazardous situation. You will never be forced to perform any procedure which you do not wish to perform. If you observe any unusual discomfort during your therapy session you have the right to refuse treatment and remove yourself from participation.

Because of the nature of the procedures performed within the clinical setting, your communication with family and friends may be restricted. **Lifestyle Physical Therapy, Inc.** reserves the right to restrict visitors and outside communication at any time during your treatment sessions to ensure you receive the maximum therapeutic value from treatment.

Based on the above information, I agree to cooperate fully, to participate in all physical therapy procedures, and to comply with the plan of care as it is established. I have read and received a copy of the consent form and authorize release of medical information to appropriate third parties. I hereby consent to physical therapy treatment.

Parents of minors: In the event of a medical emergency I understand that Lifestyle Physical Therapy will call 911. I consent for my child to be evaluated and treated by the emergency medical team.

*I give consent to share information about my treatment and/or billing to my spouse or significant other:______________________________

Patient/Parent Signature: ______________________________________Facility Witness Initials_____

Date:

Notice of Privacy Practice

I have read and understand the Notice of Privacy Practice Policy. I have been offered a copy of the policy and understand it is also available in the office and on the company website.

Patient/Parent Signature: ______________________________________Facility Witness Initials_____

Date:

Updated 02/06/19