PROTHERAPY CONCEPTS, INC
OUTPATIENT PHYSICAL THERAPY MOBILE AND IN-OFFICE

Consent for Physical Therapy Services

Consent for Physical Therapy Treatment I understand that I am a patient of Protherapy Concepts, Inc and their independent physical therapy practitioners. My care is the exclusive responsibility of the practitioners of Protherapy Concepts, Inc.

Cooperation with treatment: In order for physical therapy treatment to be effective, I must come to scheduled appointments unless there are unusual circumstances. I understand and agree to cooperate with and perform the home physical therapy program intended for me. If I have trouble with any part of my treatment program, I will discuss it with my therapist.

No warranty: I understand that there are no guarantees regarding a cure for or improvement in my condition. I understand that my physical therapist will outline and discuss goals of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

Informed consent for treatment: The term "informed consent" means that the potential risks, benefits and alternatives of physical therapy treatment have been explained to me. 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: I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury or condition. This discomfort is usually temporary; if it does not subside in a reasonable time period, I agree to contact my physical therapist.

Potential benefits: I may experience an improvement in my symptoms and an increase in my ability to perform daily activities. I may experience increase strength, awareness, flexibility, and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

Alternatives: If I do not wish to participate in the therapy program, I will discuss my medical or surgical alternatives with my physical therapist, as well as my physician or primary care provider.

Payment: I understand that I am responsible for any charges not covered by insurance. I have read the above information and I consent to physical therapy evaluation and treatment.

Patient Name (Print) _____DOB: _____

Patient or Parent/Guardian Signature: _____