Consent for Evaluation and Treatment for Physical Therapy

I acknowledge and understand that I have been referred to **Restore Motion** for evaluation and treatment for a musculoskeletal dysfunction.

I understand that to evaluate my condition it may be necessary, initially and periodically, to have my therapist perform a musculoskeletal examination. This evaluation will assess posture, skin condition, reflexes, muscle tone, length, strength and endurance, scar mobility and function. I understand that this evaluation and/or treatment could potentially elicit pain or discomfort.

Treatment may include, but not be limited to the following: observation, palpation, biofeedback and/or electrical stimulation, ultrasound, heat, cold, stretching and strengthening exercises, soft tissue and/or joint mobilization and educational instruction.

I understand that if I uncomfortable with the assessment or treatment procedures AT ANY TIME, I will inform my therapist and the procedure will be discontinued and alternatives will be discussed with me.

I have read or had read to me the foregoing and any questions, which may have occurred to me, have been answered to my satisfaction. I understand the risks, benefits and alternatives of the treatment. I understand that no guarantees have been or can be provided regarding the success of therapy. I understand that if I fail to carry out the follow-up care, I do so at my own risk. I have informed my therapist of any condition that would limit my ability to have an evaluation or to be treated. I hereby request and consent to the evaluation and treatment to be provided by the physical therapists of Restore Motion.

Date_____ Patient Name: _____
(Please Print)

_____
Patient Signature

_____
Signature of Parent or Guardian (If applicable)

_____
Witness Signature