**INFORMED CONSENT AND LIABILITY WAIVER FORM**

Physical therapy is a patient care service provided in response to a wide range of medical care needs of outpatients of all ages regardless of gender, color, ethnicity, creed, or disability. The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis and intervention.

You have the right to inquire as to the form of treatment based upon your history, diagnosis, symptoms, and testing result. You may also discuss with your physical therapist the potential risks and benefits of a specific treatment and possible alternative treatments. You have the right to decline any portion of treatment at any time or during your treatment sessions. Your physical therapist stands ready to answer any questions you may have regarding a given course of treatment, type of exercise, associated risks, and possible alternatives

I acknowledge that I have been advised that treatment may consist of rehabilitative procedures, mobilization, massage, exercises and physical agents to aid the patient in achieving their maximum potential for recovery within their capabilities.

**\_\_\_\_\_\_\_\_\_\_\_**

**Patient Initials**

I acknowledge that I understand and have been advised that all procedures will be thoroughly explained to me before I am asked to perform them. I am expected to fully cooperate with the evaluation and treatment program.

**\_\_\_\_\_\_\_\_\_\_\_**

**Patient Initials**

I acknowledge that I understand that because of the nature of services provided, I may be asked to disrobe. If this is necessary, my privacy, modesty, and dignity will be considered at all times by the staff. Should I feel uncomfortable or embarrassed, I may refuse the procedure, stop the procedure and/or request another therapist.

**\_\_\_\_\_\_\_\_\_\_\_**

**Patient Initials**

I acknowledge that I have been advised that there are certain inherent risks with physical therapy treatments because I will be asked to exert effort and perform activities with increasing levels of difficulty that could increase my level of pain or discomfort with a current or previous injury.

**\_\_\_\_\_\_\_\_\_\_\_**

**Patient Initials**

I acknowledge that I may stop treatment at any time if I feel any discomfort or pain. My therapist will take every precaution to ensure that I am protected from any potentially hazardous situation. I will never be forced to perform any procedure that I do not wish to perform.

**\_\_\_\_\_\_\_\_\_\_\_**

**Patient Initials**

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.

**\_\_\_\_\_\_\_\_\_\_\_**

**Patient Initials**

I represent and warrant that I have read the consent form and authorize the release of medical information to appropriate third parties.

**\_\_\_\_\_\_\_\_\_\_\_**

**Patient Initials**

I further hereby voluntarily release POW Physical Therapy, Jennifer Ballentine Evans and Matthew Evans from any responsibility or liability due to my participation in physical therapy. I represent and warrant that I am fully aware that I am participating in these sessions at my own risk and will not hold those named above responsible in the event of my incurring an injury or exacerbating any previously existing conditions.

**\_\_\_\_\_\_\_\_\_\_\_**

**Patient Initials**

I further represent and warrant that if I have any medical conditions, I have consulted with my physician to make sure that physical therapy is appropriate for me to participate in.

**\_\_\_\_\_\_\_\_\_\_\_**

**Patient Initials**

I am voluntarily executing this Consent Form for Treatment, and Release of Liability.

**Print Name: Signature:**

**Date:**

**If Under 18 Years of Age:**

**Parent or Legal Guardian Name and Signature:**