Core Dynamics Physical Therapy

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Informed Consent for Evaluation and Treatment:

The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to you. 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. I also acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor dysfunction.

I also acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor dysfunction. Pelvic floor dysfunctions include, but are not limited to, urinary or fecal incontinence, difficulty with bowel, bladder or sexual functions, painful scars after childbirth or surgery, persistent sacroiliac or low back pain, or pelvic pain conditions.

I understand that to evaluate my condition it may be necessary, initially and periodically, to have my therapist perform an internal pelvic floor muscle examination. This examination is performed by observing and/or palpating the perineal region including the vagina and/or rectum. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, scar mobility and function of the pelvic floor region. Such evaluation may include vaginal or rectal sensors for muscle biofeedback.

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

Potential risks: You may experience an increase in your current level of pain or discomfort, or an aggravation of your existing injury or condition. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my physical therapist.

Potential benefits: May include an improvement in your symptoms and an increase in your ability to perform daily activities. You may experience increased strength, awareness, flexibility and endurance in your movements. You may experience decreased pain and discomfort. You will have greater knowledge about managing your condition and the resources available to you.

Alternatives: All physical therapy treatment options available to your conditions will be explained to you. You may inquire about the cost of these services and discuss them with your therapist. If you do not wish to participate in the therapy program, you may discuss your medical, surgical or pharmacological alternatives with your primary care physician.

No Warranty: I understand that the physical therapist cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my physical therapist will share with me opinions and available statistics and studies regarding results of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

PLEASE NOTE: If you are pregnant, have an infection of any kind, have vaginal dryness, are less than 6 weeks postpartum or post-surgery, have severe pelvic pain, sensitivity to vaginal creams/lubricants or latex, please inform the therapist prior to the pelvic floor assessment.

Financial and insurance responsibilities:

I agree to pay for my treatments at time of service, by cash, check, or charge card unless other mutually agreed upon arrangements have been made. I understand it is my responsibility to call my insurance company ahead of time, and obtain any pre-authorization that is necessary, and get an estimate of my benefits.

COOPERATION WITH TREATMENT:

I understand that in order for physical therapy treatment to be effective, I must come to scheduled appointments unless there are unusual circumstances that prevent me from attending therapy. 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. I understand that if I cancel more than 24 hours in advance, I will not be charged**. I understand that if I cancel less than 24 hours in advance, I will pay a cancellation fee. Late arrivals disturb the treatment and will lead to a shorter visits. Please note, you will be responsible for the full session (payment).**

I have read the above information and I consent to physical therapy evaluation and treatment. I have asked any questions and they have been answered to my satisfaction. I understand the risks, benefits and alternatives to treatment. I hereby voluntarily consent to physical therapy treatment. I understand that I may choose to discontinue treatment at any time.

_____ _____

Patient Signature Date

_____

Printed Name

_____ _____

Guardian signature (if applicable) Therapist Signature / Date