BROOKLYN MAMA
PHYSICAL THERAPY

Mary Hughes-Johnson. PT, DPT, PRPC

CONSENT FOR PHYSICAL THERAPY CARE AND TREATMENT

PLEASE INITIAL EACH STATEMENT

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.

Pelvic Floor Patients:

☐ I understand that if I am referred to physical therapy for pelvic floor dysfunction, it may be beneficial for my therapist to perform a *muscle assessment and/or treatment of the pelvic floor*, initially and periodically to assess skin condition, reflexes, muscle strength, length, range of motion, and scar mobility. Observation and palpation of these muscles is most direct and accessible if done via the vagina and/or rectum.

☐ Internal examination of the pelvic floor muscles is consistent with the physical therapy practice. Evaluation and treatment of my condition may include, without limitation, observation, use of vaginal dilators, vaginal or rectal sensors for biofeedback, and/or electrical stimulation, ultrasound, education, exercise, and several manual techniques including massage, myofascial release, joint, nerve, and soft tissue mobilization

☐ I understand that the benefits of the vaginal/rectal assessment and treatment will be explained to me. I understand that if I am 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 and understand fully the above procedure(s) being performed by the physical therapist(s) at Brooklyn Mama Physical Therapy PLLC.

☐ Based on the information I have received, I voluntarily agree to standard assessment and muscular treatment techniques of the pelvic/perineal area.

☐ **Potential benefits**: I may experience an improvement in my symptoms and an increase in my ability to perform daily activities. I may experience increased 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.

☐ **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 2-3 days, I agree to contact my physical therapist.

☐ **Alternatives**: If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

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Cooperation with treatment:

☐ In order for physical therapy treatment to be effective, I must come to my scheduled appointments, except in the case of extenuating 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 my concerns 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.

☐ **Release of medical records**: I authorize the release of my medical records to my insurance company, physicians/primary care provider or other providers that are managing my care. These may be released through email, fax, or snail mail.

☐ **Chaperone request**: Any adult or minor can request a chaperone at any time.

Communication

☐ I understand that Brooklyn Mama Physical Therapy, PLLC may contact me via email or phone in regard to appointments, payments, or physical therapy advice.

☐ **I WILL INFORM MY THERAPIST OF ANY CONDITION THAT WOULD LIMIT MY ABILITY TO HAVE AN EVALUATION OR TO BE TREATED.**

☐ **I have read the above information and fully understand, request, and consent to physical therapy evaluation and treatment to be provided by the therapist.**

Patient Name:

Relation to minor:

Contact Number:

SUBMIT