Birth Portal Services

PHYSICAL THERAPY CONSENT FOR EVALUATION AND TREATMENT

I acknowledge and understand that I have been referred or self-referred for evaluation and treatment of pain, dysfunction or a condition that could be helped by receiving physical therapy.

Pelvic floor issues: 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 and treatment. This would only be offered as it pertained to my rehabilitation goals and after giving informed consent. 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; preparation for and rehab after childbirth; persistent sacroiliac, tailbone or low back pain; or pelvic pain conditions. This examination is performed by observing and/or palpating the pelvic floor region. This evaluation will assess muscle tone, length, strength, endurance, symmetry, scar mobility, skin conditions, vaginal wall laxity and function of the pelvic floor region. I hold the responsibility to inform my therapist of any condition that would limit or prohibit my ability to have an internal evaluation or treatment. Even after giving consent for evaluation and treatment, I have the right to change my mind and clearly ask the treatment be stopped. My therapist will absolutely honor that. *In Pregnancy*: I understand that my therapist is willing to teach me peroneal massage (per her book), help prepare my muscles to relax/lengthen and effectively bear down in childbirth. This work would not involve deeper structures, such as my cervix, but instead involves pelvic floor musculature. In no way does this work stimulate onset of labor. However, I understand that I could go into labor at any time and if I happen to go into labor soon after treatment, I hold the therapist harmless.

Treatment may include, but not be limited to the following: observation, palpation, soft tissue and/or joint mobilization and massage, stretching and strengthening exercises, heat, cold, educational instruction. *In Pregnancy*: I am in charge of what position is best for me and my baby/babies. If any position, including lying on my back, is causing discomfort or distress, I know I need to let the therapist know and I can change positions at any time.

Even after I've given my consent, I understand that **I have the right to cease any treatment**, whether it causes pain, makes me feel uncomfortable or unsafe or for any other reason. I understand that I must be clear about verbalizing and communicating this to the therapist so that she can respond accordingly to alter or discontinue the treatment.

Potential risks: I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury. This discomfort is usually temporary; if it does not subside in 1-3 days or is concerning to me, I agree to contact my therapist.

Potential benefits: I may experience an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements and 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, surgical or pharmacological alternatives with my physician or primary care provider.

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 therapist will share with me her opinions regarding potential results of physical therapy treatment for my condition and will discuss all treatment options with me. *I respect that therapy is administered during scheduled therapy appointments and cannot be administered over the phone or email.*

Cooperation with treatment: I understand that in order for therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from attending therapy. I agree to cooperate with and carry out the home program agreed upon in therapy sessions to the best of my ability. If I have difficulty with any part of my treatment program, I can discontinue the exercise until I discuss it with my therapist during the next scheduled appointment.

Release of medical records: I authorize the release of my medical records to my physicians/primary care provider or insurance company. I authorize physical therapist to collaborate with my healthcare practitioners regarding my care.

Appointments: Babies and children are welcome to attend appointments but I understand that tending to their needs may take up therapy time. Bringing them is better than receiving no treatment. Partners are welcome to attend appointments as you wish.

Cancellation Policy: I understand that if I cancel more than 48 hours in advance, I will not be charged. I understand that if I cancel less than 48 hours in advance or I do not show up to a scheduled appointment, I am responsible for paying $150 for the appointment slot.

Fees: I understand that after two billing cycles, my credit card will be charged for any balance owed. If there are any late cancellation/no show fees owed, they will be charged on the day of that appointment. If I need to arrange a payment plan, it my responsibility to coordinate with the biller.

I hereby request and consent to the evaluation and treatment to be provided by any physical therapist at Birth Portal Services.

_____ _____

Patient Name Date

_____ _____

Patient Signature Signature of Parent or Guardian (if applicable)

2017 Birth Portal Services form with additions courtesy of Section of Women's Health, APTA