MYOFASCIAL RELEASE OF SOUTHERN ILLINOIS

Welcome to Myofascial Release of Southern Illinois. Thank you for choosing us as your partner in health. We are committed to serving you and making your experience enjoyable and successful.

CONDITIONS & CONSENT FOR PHYSICAL THERAPY/OCCUPATIONAL THERAPY

A Word About Working with a Physical Therapist/Occupational Therapist

In the state of Illinois, physical and occupational therapists can see you for wellness and fitness purposes. For the initial treatment of an injury, you must see a Physician, Dentist, Podiatrist, Advanced Nurse Practioner, or Physician's Assistant for a diagnosis before we can see you to treat an illness or injury. If you have a specific injury, you'll need to get a diagnosis from your Physician.

Informed consent for treatment:

The term "informed consent" means that the potential risks, benefits, and alternatives of physical or occupational 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.

Potential benefits may include 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. 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 understand 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 24 hours, I agree to contact my therapist.

No warranty: I understand that my physical or occupational therapist at Myofascial Release of Southern Illinois, LLC. cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my physical or occupational therapist will share with me his/her opinions regarding potential results of therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

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.

I have read the above information and I consent to a therapy evaluation and treatment. By initialing above and signing below, I acknowledge that I have read, understood and will abide by the conditions and policies noted on this consent form.

Print name_____

Date_____

Patient's signature (if minor, parent or legal guardian must sign)

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