Lilian Holm Wellness
Physical therapy and Wellness coaching

Informed Consent For Physical Therapy Services

Physical Therapy is a patient care service that is provided in order to manage and treat a wide variety if conditions. The purpose of physical therapy is to prevent and treat disease, injury and disability through examination, evaluation, diagnosis, prognosis and intervention by use of rehabilitative procedures such as mobilization of joints and soft tissue, manipulation, exercises, patient education and physical agents etc, to help the patient reach their greatest potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery.

I understand that the response to physical therapy intervention varies form person to person; hence it is not possible to accurately predict my response to a specific procedure, exercise protocol or modality. Lilian Holm, PT, DPT does not guarantee what my reaction will be to a specific treatment, nor does she guarantee that the treatment will help resolve the condition I am seeking treatment for. Furthermore, I understand and accept that there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury. By signing this form I agree to not hold Lilian Holm, PT, DPT responsible for such perceived or real injury or aggravation. It is my right and responsibility to decline and I agree to decline any part of my treatment at any time before or during treatment, should I feel any discomfort or pain, or have other unresolved concerns. It is my right to ask my physical therapist about the treatment she has planned based on my individual history, physical therapy diagnosis, symptoms and examination results. Consequently, it is my right to discuss the potential risks and benefits involved in my treatment.

I have read this consent form and fully understand and accept the potential risks involved in physical therapy. I understand that the success of my treatment depends on my ability and willingness to cooperate and participate in all physical therapy procedures and comply with the established plan of care. I authorize the release of my medical information to appropriate third parties, such as my referring physician (MD or DO), dentist or podiatrist.

Patient name:_____Signature:_____Date:___