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. Services are provided to individuals of all ages regardless of gender, ethnicity, creed, national origin or disability.

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; mobilization of joints and soft tissue, manipulation, exercises, patient education and physical agents to help the patient reach their greatest potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. All procedures are thoroughly explained to you as needed and requested before you are asked to perform or participate in them.

Response to physical therapy intervention varies form person to person; hence it is not possible to accurately predict your response to a specific procedure, exercise protocol or modality. Lilian Holm Wellness LLC and Lilian Holm, PT, DPT does/do not guarantee what your reaction will be to a specific treatment, nor does it/she guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symtoms and may cause pain or injury.

It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns.It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symtoms and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

I have read this consent form and understand 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:___