

ReForm Physical Therapy, LLC.

1213 Texas Avenue

Alexandria, LA 71301

P: 318.955.9351

F: 318.321.1711

**Informed Consent for Evaluation and Treatment**

The term “informed consent” means that the potential risks, benefits, and alternative of therapy evaluation and treatment have been explained to you. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the evaluation, treatment and options available for my condition.

***Informed Consent for Evaluation and Treatment of Pelvic Floor Dysfunctions:***

I also acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor dysfunction.

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, persistent sacroiliac or low back pain, or pelvic pain conditions.

Treatment may include, but not be limited to the following: observation, palpation, use of vaginal weights, vaginal or rectal sensors for biofeedback and / or electrical stimulation, ultrasound, heat, cold, stretching and strengthening exercises, soft tissue and / or joint mobilization and educational instruction.

***Conditions and Consent for Treatment***

As a patient you have the right to be informed about your health condition(s) and about recommended rehabilitation treatments. This document provides information that you may use for the purpose of deciding to give or to withhold your consent to be provided with care at ReForm Physical Therapy, LLC.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, request and consent to examination and treatment for Physical Therapy and/or Massage Therapy. I further understand that I have the right to ask questions about:

• all aspects of examination and treatment, my condition, diagnosis or prognosis

• the nature or goals and potential benefits of any proposed care

• the inherent risks, complications, or side effects of treatment

• the likelihood of improvement or success following intervention

• reasonable, available alternatives to the suggested care

***Nature and Character of Treatment***

I understand that physical therapy and massage practice may involve the following:

• assessment of vitals (heart rate, blood pressure, respiratory rate)

• neuromusculoskeletal examination involving testing of reflexes, sensation, strength

• movement exam of trunk and limbs

• palpation and mobilization of soft tissues and joints

• instruction in therapeutic exercise to improve my condition

• application of heat, cold, biofeedback or electric stimulation

• education in strategies to retrain bowel or bladder habits

• instruction in exercises or strategies to utilize at home or work

***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 24 hours, I agree to contact my therapist at ReForm Physical Therapy, LLC. I have informed the therapist of any condition that would limit my ability to have an evaluation or to be treated.

***Potential benefits***

I may experience an improvement in my symptoms and an increase in my ability to perform movement and daily activities. I may experience increased strength, awareness, flexibility and endurance with activity. I may experience decreased pain and discomfort. I will learn strategies for managing my condition and resources available to me will be shared.

***Possible 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.

***Anticipated Results***

 It is anticipated that physical rehabilitation will allow improved function through decreased pain, increased strategies for managing pain, weakness, or immobility.

***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 assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

***Cancellation Policy***

**FOR EVALUATION VISITS**

* For Evaluations, we will require a missed visit fee for cancels less than 48 hours, which is half the cost of an evaluation visit, in order to reschedule.

**FOR ONGOING PATIENTS:**

* After the first no show or less than 24 hour cancel, we give you a friendly reminder of our policy.
* After the second <24 hour cancel, you will be required to pay a late cancellation fee of $50 in order to continue care
* After the second no show or third <24 hour cancel, you will be required to pay for the total of the missed visit in order to continue care as well as pre-pay for all visits.
* For long term/wellness care patients, the grace no show/cancels reset every 6 months.
* If you are sick, please cancel. We will not hold the first couple against you. If a patient has to cancel frequently due to illness, this may not be the best time to pursue treatment, until health improves enough to attend appointments.
* If there is severe weather and schools are cancelled or delayed, we may also be. Please check your phone and email before driving in on severe weather days. Please do not put yourself in harm’s way in get here, etc.

***Payment***

I have reviewed the clinic fees below and understand that I am responsible for payment at the time of service, unless previously arranged by ReForm Physical Therapy, LLC. I understand my therapist will provide me with a receipt upon request that is my responsibility to submit to my insurance company if desired. I understand it is my responsibility to call my insurance company ahead of time, and obtain any pre-authorization that is necessary, and get an estimate of my benefits.

Initial visit (55 minutes): $125

Return visit (55 minutes): $125

***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 their opinions regarding potential results of therapy treatment for my condition and will discuss all treatment options with me before I consent to treatment.

 ***I have read the above information and I consent to physical therapy evaluation and treatment.***

Printed name of patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name of guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist initials \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_