Authorization for Treatment

Physical therapy is a patient care service in response to a wide range of medical care needs of outpatients of all ages regardless of gender, color, race, creed, national origin, or disability, five days a week.

The purpose of physical therapy is to treat disease, injury, and disability by evaluation, examination, testing, and use of rehabilitative procedure, manipulations, massage, exercise, and physical agents including, but not limited to, mechanical devices, heat, cold, air, light, water, electricity, and sound in the aid of diagnosis or treatment; to prevent or minimize residual and mental disability; to aid the patient in achieving their maximum potential within their capabilities; and no accelerate convalescence and reduce the length of the functional recovery. Physical therapy practice includes, but is not limited to, the use of: Electromyography (EMG) tests, Nerve Conduction Velocity (NCV) tests, Thermography, Transcunaneous Electrical Nerve Stimulation (TENS), bed traction, application of topical medication to open wounds, sharp debridement, provision of soft goods, inhibitive casting and splinting, Phonophoresis, Iontophoresis, and Biofeedback services. All procedures will thoroughly be explained to you before you are asked to perform them.

You are not expected to experience any increase in your current level of pain or discomfort. You should attempt to stop each procedure before you experience any increase in your current level of pain or discomfort.

Because of the nature of services provided, you may be asked to disrobe or partially disrobe. If this is necessary, your privacy, modesty, and dignity will be considered at all times by the staff. Should you feel uncomfortable or embarrassed, you may refuse the procedure, stop the procedure and/or request another therapist.

There are certain inherent risks with physical therapy treatment because you will be asked to exert effort and perform activities with increasing degree of difficulty, which could cause an increase in your current level of pain or discomfort, or an aggravation to your existing injury. There is also a possibility that you could experience a new injury, but this risk is small. You will be able to control any procedure by stopping if you feel any increase in pain or discomfort. You will also be able to stop treatment if you feel any discomfort in any other part of your body. The physical therapist or physical therapist assistant will take every precaution to ensure that you are protected from any potentially hazardous situation. You will never be forced to perform any procedure, which you do not wish to perform.

Because of the nature of the procedures performed within the clinical setting, your communication with family and friends may be restricted. The department reserves the right to restrict visitors and outside communication at any time during your treatment sessions to ensure you received the maximum therapeutic value from treatment. The law requires all staff members to report any evidence of abuse, neglect, and/or exploitation of patients. Should you wish to file a complaint or grievance for any reason, you will be provided, in written form, with names and addresses of appropriate individuals and protective agencies and, if necessary, be given appropriate privacy to complete your communication with those individuals/agencies.

Based on the above information, I agree to cooperate fully and to participate in all physical therapy procedures and to comply with the plan of care as it is established. I acknowledge that I have read and received copies of the Authorization for Treatment and Patient's Rights and Responsibilities, and authorize release of medical information to appropriate third parties.

Also, to the best of my knowledge, I am NOT currently pregnant or receiving or have ever received treatment for any malignancies.

Notice to Patients:

For your personal safety, do not use any equipment without a staff member present. For your protection, random audio and video surveillance may be conducted in this facility in accordance with applicable State and Federal laws.

Date: _____ Patient Signature: _____

Date: _____ Witness: _____