

## Informed Consent For Occupational and Physical Therapy

### **COOPERATION WITH TREATMENT:**

I understand that in order for any therapy treatment to be effective, I must come to scheduled appointments unless there are unusual circumstances that prevent me from attending therapy. I understand and agree to cooperate with and perform the home therapy program intended for me. If I have trouble with any part of my treatment program, I will discuss it with my therapist. I understand that if I cancel more than 24 hours in advance, I will not be charged. I understand that if I cancel less than 24 hours in advance, I will pay a cancellation fee of \$50.

### **NO WARRANTY:**

I understand that the 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 opinions and available statistics and studies regarding results of therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

### **INFORMED CONSENT FOR TREATMENT:**

The term "informed consent" means that the potential risks, benefits, and alternatives of 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 treatment and options available for my condition.

**Potential risks:** You may experience an increase in your current level of pain or discomfort, or an aggravation of your existing injury or condition. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my therapist.

**Potential benefits:** May include an improvement in your symptoms and an increase in your ability to perform daily activities. You may experience increased strength, awareness, flexibility and endurance in your movements. You may experience decreased pain and discomfort. You will have greater knowledge about managing your condition and the resources available to you.

**Alternatives:** All therapy treatment options available to your conditions will be explained to you. You may inquire about the cost of these services and discuss them with your therapist. If you do not wish to participate in the therapy program, you may discuss your medical, surgical or pharmacological alternatives with your primary care physician.

### **Financial and insurance responsibilities:**

I agree to pay for my treatments at time of service, by cash, check, or charge card unless other mutually agreed upon arrangements have been made. 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. I understand my therapist will provide me with a receipt and, that is my responsibility to submit to my insurance company.

**I have read the above information and I consent to evaluation and treatment. I have asked any questions and they have been answered to my satisfaction. I understand the risks, benefits and alternatives to treatment. I hereby voluntarily consent to treatment. I understand that I may choose to discontinue treatment at any time.**

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Patients signature

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Date

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Printed Name

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Guardian signature (if applicable)

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Therapist signature / Date