497 Ritchie Highway
Suite 1A&B
Severna Park, MD 21146
410-775-5335
erica@blueskywellnesspt.com

Consent for Evaluation and Treatment

I acknowledge and understand that I am a patient of Blue Sky Wellness and my care is the exclusive responsibility of the practitioners of Blue Sky Wellness. I hereby consent to the evaluation and treatment of my condition. The physical therapist will explain the nature and purposes of these procedures, evaluation, and course of treatment. The physical therapist will inform me of expected benefits and potential complications, discomforts, and risks that may arise, as well as alternatives to the proposed treatment and any risks and consequences, as well as the risks of non-treatment.

Cooperation with treatment: In order for physical therapy treatment to be effective, I must come to scheduled appointments unless there are unusual circumstances. I understand and agree to cooperate with and perform the home physical therapy program intended for me. If I have trouble with any part of my treatment program, I will discuss it with my therapist.

No warranty: I understand that there are no guarantees regarding a cure for or improvement in my condition. I understand that my physical therapist will outline and discuss goals of physical 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 physical therapy treatment have been explained to me. 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: 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 a reasonable time period, I agree to contact my physical therapist.

Potential benefits: I may experience an improvement in my symptoms and an increase in my ability to perform daily activities. I may experience increased strength, awareness, flexibility, and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

Alternatives: If I do not wish to participate in the therapy program, I will discuss my medical, surgical, or pharmacological alternatives with my physical therapist, as well as my physician or primary care provider.

Patient Name (Print)____ Date___________

Patient or Parent/Guardian Signature____