Stracker Physical Therapy, Inc.

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Consent to Therapeutic Procedures

I, _____, hereby consent to the therapeutic procedures outlined below, to be performed by Stracker Physical Therapy, Inc.

-Evaluation and treatment of nerve, muscle, and skeletal dysfunction and/or pain.
-Evaluation and treatment of functional limitation.
-Other: _____

Evaluation includes assessment of possible contributors to pain, dysfunction, and/or functional limitation. It may involve, but is not limited to: tests of joint mobility, muscle flexibility, soft tissue restriction, muscle strength, nerve function, vestibular function, and/or functional movement patterns.

Treatment is based on findings from the evaluation, with the goal of decreasing pain and/or improving function. Procedures may include, but are not limited to: joint mobilization, stretches, soft tissue mobilization, strengthening exercises, cardiovascular exercises, and/or functional training. Risks inherent to manual treatment and exercise include post-treatment soreness and possible exacerbation of symptoms.

These procedures have been explained to me to my satisfaction, including the nature and extent of the evaluation to be performed, and any risks involved in physical therapy evaluation and/or treatment.

I understand that I may consult with other health care providers regarding my condition, and I have the right to refuse any therapeutic procedure or treatment at any time.

I understand that no guarantee of a successful outcome can be provided to me.

Any questions I thought were important in deciding whether or not to undergo physical therapy evaluation and treatment have been answered to my satisfaction. I understand I may ask additional questions at any time.

I certify that I have read the above statement, that I understand the explanations of the procedures, and that my consent to physical therapy evaluation and treatment is given freely and voluntarily.

_____ _____
Patient or Responsible Party Signature Date

I further certify that I have received, read, and consent to the Notice of Privacy Practices.

_____ _____
Patient or Responsible Party Signature Date