



PELVIC FLOOR CONSENT FOR EVALUATION AND TREATMENT

INFORMED CONSENT FOR TREATMENT:

The term “informed consent” means that the potential risks, benefits, and alternatives 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.

I also acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor, bladder, sexual functions, painful scars after childbirth or surgery, persistent sacroiliac or low back pain, or pelvic pain conditions.

I understand that to evaluate my condition it may be necessary, initially and periodically, to have my therapist perform an internal pelvic floor muscle examination. This examination is performed by observing and/or palpating the perineal region including the vagina and/or rectum. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, scar mobility, and function of the pelvic floor region. Such evaluation may include vaginal or rectal sensors for muscle biofeedback.

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.

POTENTIAL RISKS: I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury. This discomfort is usually temporary; if it does not subside in 1-3 days, I agree to contact my therapist.

POTENTIAL BENEFITS: May include an improvement in my symptoms and an increase in my ability to perform my 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 physician or primary care provider.

RELEASE OF MEDICAL RECORDS: I authorize the release of my medical records to my physicians/primary care provider or insurance company.

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. I understand that there will be a charge of \$21.00 for no-showing appointments scheduled.

CANCELLATION POLICY: I understand that the physical therapist cannot make any promises or guarantees regarding a cure for, or improvement in my condition, and will discuss all treatment options with me before I consent to treatment.

I have informed my therapist of any condition that would limit my ability to have an evaluation or to be treated. I hereby request and consent to the evaluation and treatment to be provided by the therapist and therapy assistants and technicians of Plymouth Physical Therapy Specialists.

DATE: _____ **PATIENT NAME:** _____

PATIENT SIGNATURE: _____

PARENT OR GUARDIAN (IF APPLICABLE): _____

WITNESS SIGNATURE: _____

