

## Ando & Aston Physical Wellness Therapy Consent to Therapeutic Procedures

I, \_\_\_\_\_ hereby consent to the therapeutic procedures outlined below, to be performed by &o & Aston Physical Therapy, Inc. & their associates.

\_\_\_\_\_ Evaluation & treatment of nerve, muscle & skeletal dysfunctions &/or pain.

\_\_\_\_\_ Evaluation & treatment of functional loss.

\_\_\_\_\_ Other: \_\_\_\_\_

- A. I understand the following regarding the proposed evaluation & treatment.
1. The nature & the extent of the evaluation procedure to be performed, including any risks.
  2. Medically necessary treatments may include:
    - Joint & soft tissue mobilization to prepare my body to exercise.
    - I will be trained in exercises prescribed by my Physical Therapist, a video home exercise program link may be emailed to me. Advanced exercises such as Pilates are used on a case-by-case basis.
    - One-on-one functional retraining such as postural & body mechanics training will present me with options to promote healing, & avoid future injury.
    - Modalities such as heat, ice, electrical stimulation, iontophoresis, & ultrasound.
  3. I will be treated by several team members qualified to see my case, including PT students/interns.
  4. While pain relief is an important goal, it may take a week or two for this to happen.
  5. There is minor risk of temporary increased symptoms with treatment.
- B. I understand & agree to the following:
1. I will abide by clinic scheduling rules regarding tardiness, rescheduling, & cancellation.
  2. Treatment frequency & duration will be determined by medical necessity & coverage.
  3. I agree to do my home exercise program and acquire equipment as directed.
  4. I have read & understand the Financial Policies as they affect my care/services.
  5. I have the right to refuse any therapeutic procedure or treatment at any time.
  6. No guarantees of successful outcome have been given to me.
  7. Minors. Parents/guardians must attend all treatments unless agreed to otherwise in writing. Minors are supervised while in our offices, but not in public areas of the building.
  8. Non-medically necessary Wellness services such as acupuncture are available on a cash basis.
  9. I may ask questions at any time.

I certify that I have read the above consent statement, that I understand the explanations of the procedures, & that this consent is given freely, voluntarily, & without reservation.

\_\_\_\_\_  
Patient or Responsible Party Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physical Therapist, PTLA or PT Intern Signature

\_\_\_\_\_  
Date