CONSENT FORM
PHYSIOTHERAPY

PATIENT'S NAME:_____ **D.O.B:**_____

Physiotherapy treatment is generally an effective and safe form of treatment, however like all forms of medical treatment there are benefits and risks involved. The physical response to treatment varies and cannot always be predicted as every individual is different. The purpose of this form is you let you know what your rights are and how we address the issue of a collaborative decision making and informed consent between the physiotherapist and patient.

Physiotherapist in this practice will discuss your condition and options for treatment with you so that you are informed properly and can make a decision relating to treatment. You may choose to consent or refuse any form of treatment for any reason including religious or personal grounds. Once you have given consent, you may withdraw that consent at any time. Your decision to accept or decline physiotherapy services at this clinic will **not affect** the quality or continuation of medical care with the doctor or within this clinic. You will continue to receive the same standard of care regardless of your decision regarding physiotherapy.

PLEASE READ AND SIGN THE FOLLOWING:

QUESTIONS OF A PERSONAL NATURE
Your physiotherapist may ask personal questions relating to your current condition or injury and how this condition or injury impacts on your activities of daily living. The more information that is given to the physiotherapist the more likely it is to provide effective treatment options. It is your choice as to how much information you choose to provide. If you feel uncomfortable with any questions, please do not hesitate to advise the physiotherapist.

PHYSICAL CONTACT
During your examinations, assessments and treatment it may be necessary for the physiotherapist to make physical contact. Every effort is made to preserve modesty and keep you comfortable. Physical consent requires your verbal consent. You may withdraw consent at any time at which point, all physical contact will cease immediately. Please inform your physiotherapist if you feel uncomfortable at any time.

RISKS RELATED TO TREATMENT
The physiotherapist will discuss the risks and benefits with you prior to administering treatments. You may be required to read information related to particular treatments and they may request that you sign a further consent form. This is the ensure you understand, and risks involved. You may withdraw your consent at any time.

FREEDOM OF CHOICE
I understand that I have the right to choose where I receive physiotherapy services. I am under no obligation to have my physiotherapy treatment at this clinic and may see care from any physiotherapist provider of my choice.

FINANCIAL DISCLOSURE
I understand that the clinic and/or doctor may receive financial benefit or profit from the physiotherapy services and related products provided at this clinic. This does not influence the quality or appropriateness of the care offered.

VOLUNTARY PARTICIPATION
I confirm that I am participating in physiotherapy services voluntarily and that all aspects of my treatment, including goals, techniques and expected outcomes, it will be explained to me before commencing therapy. I understand I may withdraw from physiotherapy at any time.

SUBSTIUTED CONSENT
Where a person is incapable of understanding the risks and benefits of treatment, consent may be provided by another person who is legally authorised to provide. Evidence of legal authorisation will be required.

IMPORTANT INFORMATION WE NEED TO KNOW

The risks related to some treatments can increase if the physiotherapist is not aware of certain facts. Please inform the physiotherapist if you have any of the following:

Do you have a pacemaker or heart condition	☐ Yes ☐ No
Do you Suffer from blood clots, thrombosis or had a stroke	☐ Yes ☐ No
Do you suffer from diabetes	☐ Yes ☐ No
Are you currently taking medication	☐ Yes ☐ No

PLEASE LIST CURRENT MEDICATIONS BELOW:

MEDICATION	DOSAGE

PLEASE STATE BELOW ANY OTHER IMPORTANT INFORMATION YOU WISH TO DISCLOSE WITH YOUR PHYSIOTHERAPIST

_____

_____

_____

_____

_____

I _____ **(Full Name)** have read and understood the abovementioned statement relating to the consent for physiotherapy treatment. My questions have been answered to my satisfaction. I consent to participate in physiotherapy services at this clinic under the terms describes above. I agree to this consent remaining valid until such time as I withdraw my consent.

SIGNATURE:_____**DATE:** _____

WITNESS NAME: _____ **SIGNATURE**:_____ **DATE:** _____