Consent for Evaluation and Physical Therapy Treatments

I acknowledge and understand that I am seeking and/or have been referred to **AB Neuromuscular Physiotherapy, LLC** for evaluation and treatment of musculoskeletal or neuromuscular dysfunction.

I understand that, to evaluate my condition, it may be necessary, initially and periodically, to have my therapist perform a musculoskeletal examination. This evaluation will assess posture, reflexes, and muscle tone, length, strength and endurance, mobility and function. I understand that this evaluation and/or treatment could potentially elicit pain or discomfort.

Treatment may include, but not be limited to the following: observation, palpation, biofeedback and/or electrical stimulation, ultrasound, heat, cold, stretching and strengthening exercises, soft tissue manipulation, dry needling, joint mobilization, and educational instruction.

I understand that if I am uncomfortable with the assessment or treatment procedures AT ANY TIME, I will inform my therapist and the procedure will be discontinued and alternatives will be discussed with me.

I have read or had read to me the foregoing and any questions, which may have occurred to me, have been answered to my satisfaction. I understand the risks and benefits of and alternatives to treatment.

I understand that no guarantees have been or can be provided regarding the success of therapy.

I understand that if I fail to carry out the follow-up care, I do so at my own risk.

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 physical therapists of **AB Neuromuscular Physiotherapy, LLC**.

Date: _____

_____ _____

Patient Name (please print) Signature of Parent or Guardian (If applicable)

_____ _____

Patient Signature Witness Signature