CONSENT TO PHYSICAL THERAPY

Adult patients have the basic right to make their own health care decisions. Patients who are minors or who are not competent to make medical decisions have the right to have their parent or legal representative make medical decisions on their behalf. To exercise this right, a patient is entitled to the information necessary to make an informed decision whether to consent or to refuse treatment. By signing this form, I acknowledge that, with respect to services rendered by Romy Havard, PT, DPT, OCS and/or Peregrine Physical Therapy, and their employees and agents (collectively "Provider"), I understand the following.

1. Direct Physical Therapy Treatment Services

You are receiving direct physical therapy treatment services from an individual who is a physical therapist licensed by the Physical Therapy Board of California. Under California law, you may continue to receive direct physical therapy treatment services for a period of up to 45 calendar days or 12 visits, whichever occurs first, after which time a physical therapist may continue providing you with physical therapy treatment services only after receiving, from a person holding a physician and surgeon's certificate issued by the Medical Board of California or by the Osteopathic Medical Board of California, or from a person holding a certificate to practice podiatric medicine from the California Board of Podiatric Medicine and acting within his or her scope of practice, a dated signature on the physical therapist's plan of care indicating approval of the physical therapist's plan of care and that an in-person patient examination and evaluation was conducted by the physician and surgeon or podiatrist.

_____Patient's Signature _____Date

With your written authorization below, Provider will notify your physician and surgeon, if any, that Provider is treating you. Your physician is:

Name:
Address:
Phone:
Email:

X_____Patient's Signature _____Date

Provider will refer you to a physician surgeon (or to a person licensed to practice dentistry, podiatric medicine, or chiropractic) if at any time, you have signs or symptoms of a condition that requires treatment beyond the scope of Provider's practice or if you are not progressing toward documented treatment goals as s demonstrated by objective, measurable, or functional improvement.

Provider has given adequate, intelligible information about the proposed physical therapy, including a clear explanation of the risks, benefits, and alternatives to physical therapy treatment.

2. Benefits of Provider's Approach and Scope of Practice

I understand that Provider uses diagnostic and treatment methods within her scope of practice as a licensed physical therapist. Physical therapy ("PT") improves mobility and motion, reduces pain, reduces risk of injury, improves balance and reduces fall risk, rehabilitates movement after injury or disease, helps to manage chronic illnesses, reduce need for medications, and helps prevent surgery. Therapists train caregivers to improve safety and efficiency during caregiving tasks. PT has also been shown to help improve mood and psychological conditions, improve sleep, and improve overall quality of life.

3. Risks

The primary risks of physical therapy include side effects of exercise, such as risk of increased fatigue, muscle soreness or strain, swelling, pain, aggravation of injury, risk of fall, and lack of progress toward goals. There is a risk of skin irritation with use of thermal modalities, topical lotions, and tape adhesives. As with any physical activity, there is a small risk of death. I understand that, notwithstanding the risks set forth herein, Provider only employs treatments she believes to be safe and effective.

4. Alternatives

As alternatives, Provider encourages me to speak with and consider the advice of other clinicians regarding my overall care. Patients who do not wish to pursue physical therapy can discuss medical, pharmacological, or surgical alternatives with their physician. Alternatives to specific modalities can be discussed with the PT.

5. General

No Claims or Guarantees: I am responsible to disclose to Provider all medication, care, treatment, diagnoses, and assessments that I receive elsewhere and to provide medical records from other providers to ensure that care is coordinated and compatible. I understand that Provider makes no representations, claims or guarantees that my medical problems or conditions will be cured, solved, or helped by undergoing treatment by Provider.

Referrals: I understand that Provider's treatment may include recommendation that I seek other types of treatment from other health professionals who are not affiliated with Provider. I understand that Provider does not supervise these professionals and is not responsible for them. I understand that they are not Provider's employees and that they will bill separately for their services.

Ancillary Products: From time to time, Provider may make available products for sale to her patients. To the extent there is a usual and customary markup on these products, Provider has a financial interest in sales of these products. I understand that I am not obligated to purchase these products, and can purchase products from any source of my choosing. I understand that the health care services I am offered will not be affected if I choose to purchase similar products elsewhere. I understand that while Provider may recommend products, Provider is not responsible for results from using those products, and makes no warranties or claims regarding use of the same.

Follow-Up Care: I understand that Provider may follow up with me by phone or online while I am traveling in other states or between visits.

6. Assumption of Risk; Indemnity. I knowingly, voluntarily, and intelligently decide to receive the services described above, and I knowingly, voluntarily, and intelligently assume all risks involved in the same. As a result of my assumption of these risks, I agree to release, hold harmless, indemnify, and defend Provider from and against any and all claims which I (or my representatives) may have for any loss, damage, or injury arising out of or in connection with use of the services described above, or arising out of or in connection with referral to other practitioners or merchants for delivery of any services. As a result, I agree not to pursue a claim against Provider, simply because I am dissatisfied with the results of the above services.

NOTE: DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT AND FEEL THAT YOU UNDERSTAND IT. ASK ANY QUESTIONS YOU MIGHT HAVE BEFORE SIGNING THIS FORM. DO NOT SIGN THIS FORM IF YOU HAVE TAKEN MEDICATIONS WHICH MAY IMPAIR YOUR MENTAL ABILITIES OR IF YOU FEEL RUSHED OR UNDER PRESSURE.

I have carefully read this form and acknowledge that I understand it. I have had opportunities to ask questions, and accept and agree to all of the terms above. No representations, statements, or inducements, oral or written, apart from the foregoing written statement, have been made. If any portion of this form is held invalid, the rest of the document will continue in full force and effect.

Name
Patient Signature
Signature
Date

Fill out below if someone other than the patient is signing this form.
Signature
Name
Title/Relationship to Patient
Authority to Sign Document
Date

WITNESS (optional)
Signature
Name
Date