

Informed Consent to Assessment and Treatment

I hereby request and consent to the performance of physical assessment/ treatment procedures on me by the Registered physical therapist identified below. My consent is voluntary and I intend this consent form to cover the entire course of assessment/ treatment for my present condition, commencing on the date indicated below.

I understand that I may ask questions at any time regarding:

- What the assessment/ treatment is
- Who will be performing the assessment/ treatment
- The reasons why I should have the assessment/ treatment
- The alternatives to having the assessment/ treatment
- What might happen if I do not have the assessment/ treatment
- What potential risks and/ or side effects exist for the proposed assessment/ treatment

I understand that this consent may be withdrawn, in writing, at any time, except for actions already taken.

Consent to Assessment and Treatment

Patient Signature	Printed Name	Date		
		YYYY	MM	DD

Clinician Signature	Printed Name	Date		
	Charlotte Savela, PT BHsc HBPHE	YYYY	MM	DD

Consent to Disclose Personal Health Information

I hereby grant permission for Charlotte Savela, PT to correspond with my physician(s) to obtain and exchange information relevant to my treatment. I realize that any information so obtained will be held in strict confidence.

Patient Signature	Printed Name	Date		
		YYYY	MM	DD