Patient Name

DOB:

MR #

UW Health **uwhealth.org**
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CONSENT FOR PHYSICAL THERAPY

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Date: _____

I have been given information about my condition and the physical therapy evaluation, so that I will be better informed to give or withhold my consent to my evaluation. This consent form is a written confirmation of such a discussion.

My therapist has discussed my condition with me. Therapy has been proposed for my diagnosis and treatment. The reason for and potential benefits from this evaluation and treatment have been explained to me. The logistics of the evaluation and treatment have been reviewed. Other reasonable diagnosis and treatment options have been discussed with me, as well as their risks and benefits. I understand the potential consequences to me if no evaluation or treatment is given.

I understand that as I undergo my evaluation, my treatment plan may evolve. If so, my therapist will further discuss with me my condition, possible alternate reasonable treatment options (and their potential risks and benefits), and potential risks and benefits of continued therapy evaluation and treatment. Then, my therapist will obtain verbal consent from me to continue therapy.

Even if I undertake therapy, I understand that there is a risk that my condition will not improve or possibly worsen. I may experience common side effects such as increased muscle/joint soreness or pain. Rarely, I understand there is a risk of other problems, despite all safety measures taken. Certain underlying conditions may increase the risk and severity of problems.

I understand that I may request at any time to have another person in the room with the therapist and me while services are provided.

I understand that I may withdraw my consent to evaluation and treatment and stop participating in therapy at any time. If I wish to do so, I will tell my therapist either verbally or in writing that I no longer wish to receive therapy. I understand that my therapist will not provide me with therapy after that time, unless I decide to consent to therapy again in the future. At that time, my therapist will ask me to re-sign this form.

I understand that my therapist does not have sufficient information to provide me with information regarding costs of my treatment or billing. If I have any billing concerns, I may request the “procedure code” from my therapist, and contact UWHC’s price line specialists at (608) 263-1507. I may also wish to verify coverage of treatment with my insurance company, if applicable.

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I have read this form and talked with my therapist. I understand the potential benefits and risks of the proposed therapeutic evaluation and treatment at this point in time, as well as other types of evaluation and treatment.

I consent to have the therapy described to me given under the care of my therapist. Other care givers may also assist.

AUTHORIZING SIGNATURES

Signature of Patient/Representative _____Date: _____ Time: _____AM PM

If signed by person other than the patient, print name and state relationship and authority to do so.

Print Name: _____Relationship: _____

Patient is: ☐ Minor ☐ Incompetent / Incapacitated

Legal Authority: ☐ Legal Guardian ☐ Parent of Minor ☐ Health Care Agent ☐ Other

Provider Signature: _____ Print Provider Name: _____

Date: _____ Time: _____AM PM Pager# _____

_____ Interpreter or Reader Signature (if applicable)

_____ Witness Signature*

_____ Print Interpreter or Reader Name

_____ Print Witness Name

_____AM PM
Date Time

_____AM PM
Date Time

* Only required if patient signature not obtained by provider or when telephone consent obtained.