INTEGRATIVE HEALTH INSTITUTE

Good health enables empowered, authentic living.

Physiotherapy - Informed Consent

PLEASE NOTE THAT THIS FORM MUST BE SIGNED PRIOR TO YOUR 1ST APPOINTMENT

Physiotherapy is a form of rehabilitation that addresses the health of the body in recovering from injury, illness, pain, and general dysfunction through a variety of treatment modalities and exercise. Myofascial Release is a holistic, hands-on treatment that addresses the above issues, observing the alignment of the whole body and applying gentle, sustained pressure into areas of restriction to aid in healing and re-alignment.

The physiotherapist has explained to me the nature and purposes of the assessment and treatment that I am to receive in the context of the risks and side effects of physiotherapy, including Myofascial Release. I have been advised where applicable of the alternatives to treatment, including the risks of no treatment. I understand that it is my responsibility to disclose the nature and extent of my injury or illness to my therapist to maximize the benefits and reduce the risks of treatment.

I recognize that physiotherapy care will involve the touching of my body by the physiotherapist, and that partial disrobing is required to facilitate such care.

I understand that the treatment may change at the therapist's discretion and if, at any time, I am not comfortable with or do not understand the purpose of any treatment procedure, I will ask the physiotherapist for further explanation. I understand that I may stop the assessment or treatment procedure at any time.

I understand that the results of treatment are not guaranteed and that the proposed course of treatment may temporarily cause additional discomfort or pain or aggravate my condition. I have been given the opportunity to ask questions, and all of my questions have been answered to my satisfaction.

I consent to the use of still photography and/or video analysis as a component of my physical therapy assessment. I will be made aware that these photos or videos are being taken, and they will be used only for the purposes of assessment in my plan of care. Any photos or videos taken will be part of my confidential medical record and cannot be reproduced or otherwise used without my written consent.

I have read and understood the above information and voluntarily consent to physiotherapy care, as recommended and discussed with my physiotherapist. I intend for this consent to apply to my present and future physical therapy care.

Patient Name (please print):_____

Signature of Patient or Guardian:_____Date:_____

Physical Therapist (print):_____PT Signature:_____

The vision of the Integrative Health Institute is to provide true integrative medical services. Given our commitment to this best-patient practice, we will communicate with your other medical providers at the clinic to ensure that you are receiving true complementary care. This will be done with respect for all privacy laws and any restrictive stipulation you may have placed on this communication. Please speak to your practitioner if you would like more clarification on this process.

I welcome professional dialogue regarding my case between members of my medical team at the Integrative Health Institute: Yes I No

Signature: _____

Integrative Health Institute
46 Sherbourne Street, 2nd Floor I Toronto ON I M5A2P7 I 416.260.6038

INTEGRATIVE HEALTH INSTITUTE

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