Informed Consent for Physiotherapy Assessment and Treatment

& Authorization to Release Medical Information

Informed Consent

I understand that, in order to diagnose my condition and make treatment recommendations, a physical assessment involving physical contact is required.

I understand that Terry Kane is a male physiotherapist and I have been offered the opportunity to bring a friend or family member to witness and be present at all times during any appointment. I understand that Terry Kane is not able to provide a witness and therefore accept that it is my responsibility to make necessary arrangements to secure a witness if I wish to have one present.

I understand that I will have the right to be informed of Terry Kane's assessment findings and treatment recommendations before proceeding to any form of treatment or exercise.

I understand that I have the right to terminate an appointment or decline any treatment at any time.

Treatment recommendations may include any of the following;

1. Education on my condition, my prognosis and my treatment options.
2. Education on self-management strategies and home based rehab exercises (examples: stretching, strengthening)
3. Manual therapy may be used to restore or improve range of motion in stiff joints or tight muscles.
4. Canal re-positioning maneuvers (if being assessed and treated for vestibular problems such as vertigo).

I understand that Terry Kane does not assess or treat patients with injuries resulting from motor vehicle accidents, work related accidents nor patients involved medical-legal litigation.

Authorization to Release Medical Information

After consulting with Terry Kane, if my diagnosis or treatment may be enhanced by communicating with my family physician and / or an orthopaedic surgeon, I authorize Terry Kane to share and exchange information with my family physician and / or orthopaedic surgeon.

By signing below, I _____ (client name), consent that I have read the above information and (1) provide informed consent for physiotherapy assessment /treatment and (2) authorize Terry Kane to share and exchange information regarding my assessment and treatment with my family physician for the purpose of enhancing my treatment and/or rehabilitation.

CLIENT SIGNATURE: _____DATE: _____

WITNESS SIGNATURE: _____ DATE: _____