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Physiotherapy Consent Form

Dear Patient:

Physiotherapists are highly educated and skilled primary health care practitioners who are trained in treating musculoskeletal injuries.

Physiotherapy involves many different types of physical evaluation and treatment. As with all forms of medical treatment, there are benefits and risks involved with physiotherapy. The physical response to treatment varies and cannot always be predicted as every individual is different. While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures. There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy.

During your physiotherapy visit, it is often necessary to expose and touch the area in need of treatment. Every effort is made to preserve modesty and keep you comfortable. Please communicate to your therapist if you have any concerns during the treatment.

By signing this, I hereby consent to the rendering of a physiotherapy evaluation and treatment as deemed appropriate by the treating therapist. I have the right to decline treatment at any time. The therapist will explain your physiotherapy diagnosis and discuss treatment recommendations with you. Physiotherapy, as with any type of medical care, is the most effective if you participate according to the treatment plan agreed upon with your therapist. If at any time you have questions regarding treatment and services provided, please do not hesitate to talk to your therapist.

Physiotherapists may delegate certain portions of treatment to a Physiotherapist Assistant including but not limited to Ultrasound, IFC, and exercises. Any part of the treatment that has been assigned has been ordered by the treating physiotherapists. The assistants have been properly trained to perform these tasks and the treating physiotherapists will be available to supervise/monitor. I understand and agree that part of my treatment may be delegated to an assistant.

All personal and health information are kept confidential and are not distributed without the consent of the patient. To learn more about our privacy policy, please do not hesitate to talk to any of the staff.

I authorize the release of all necessary information including status updates to my primary care provider, physician, and/or to a co-treating practitioner at Dynamic.

I have read this form and agree to all consent regarding physical therapy evaluation and treatment.

Dated this _____ day of _____, 20_____.

Patient Name (Please Print) _____

Patient Signature (Legal Guardian)

Witness Signature