Consent Form – Therapy Services

The patient authorizes the Physical and/or Occupational Therapist to examine and treat the condition as he/she deems appropriate through the use of physical/occupational therapy measures, and the patient gives authorization for these procedures to be performed.

The patient has the right to informed participation in decisions involving his/her health care. This shall be based on clear, concise explanation of his/her condition and of all proposed treatment procedures. All possible risks and/or side effects as well as the probability of success with such procedures shall be disclosed to the patient by his/her attending Physical and/or Occupational Therapist. The patient will not hold the Physical and/or Occupational Therapist responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

The patient has the right to know who is responsible for authorizing and performing any and all treatment procedures.

The patient shall not be subjected to any procedure without his/her voluntary, competent, and understanding consent or the consent of his legally authorized representative. Where medically significant alternatives for care or treatment exist, the patient shall be so informed.

The patient shall be advised if Orthopedic Associates of Lancaster, Ltd. (OAL) proposes to engage in or perform human experimentation, for the purpose of research, affecting his/her care. The patient has the right to refuse to participate in such research projects.

After reading the above (or having it read to me), I _____
Hereby consent to receive physical therapy at OAL, commencing on _____ and terminating when determined by myself, my physician or my Physical and/or Occupational Therapist.

I have read (or have had read to me) the above information and understand the content.

_____ _____
Patient (or Guardian) Signature Date

_____ _____
Witness Signature Date