Marina D. Castellanos PT, PLLC

PEDIATRIC CONSENT FOR EVALUATION AND TREATMENT

Informed consent for treatment:

The term "informed consent" means that the potential risks, benefits, and alternatives of therapy evaluation and treatment have been explained. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the evaluation, treatment and options available for my condition.

I also acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor dysfunction. Pelvic floor dysfunctions include, but are not limited to, urinary or fecal incontinence, difficulty with bowel or bladder functions, or pelvic pain conditions.

I understand that to evaluate my condition it may be necessary, initially and periodically, to have my therapist perform a pelvic floor muscle examination. This examination is performed primarily by observing and/or palpating the external perineal region. No internal examination is done. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, and function of the pelvic floor region.

Treatment may include, but not be limited to the following: observation, palpation, biofeedback and/or electrical stimulation, stretching and strengthening exercises, soft tissue and/or joint mobilization and educational instruction. Treatment may also include _____

Potential risks: I may experience an increase in my current level of pain or discomfort if any, or an aggravation of my existing injury. This discomfort is usually temporary; if it does not subside in 1-3 days, I agree to contact my physical therapist.

Potential benefit: I may experience an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

Alternatives: If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

Release of medical records:

I authorize the release of my medical records to my physicians/primary care provider or insurance company.

Cooperation with treatment:

I understand that in order for therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from attending therapy. I agree to cooperate with and carry out the home physical therapy program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

Cancellation Policy

I understand that if I cancel more than 24 hours in advance, I will not be charged. I understand that if I cancel less than 24 hours in advance, I will pay a cancellation fee of $50.00

No warranty: I understand that the therapist cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my therapist will share with me her opinions regarding potential results of treatment for my condition and will discuss all treatment options with me before I consent to treatment.

Financial and Insurance Responsibilities I agree to pay for my treatments at time of service, by cash, check, or charge card unless other mutually agreed upon arrangements have been made. I understand it's my responsibility to call my insurance company ahead of time, and obtain any pre-authorization that is necessary, and get an estimate of my benefits. I understand that my therapist will provide me with a receipt for services.

Direct Access: I understand that I may seek treatment rendered by a licensed PT in New York State without a physician referral for 10 visits or 30 days, whichever comes first. I understand services provided, without a referral, may not be covered by my health plan or insurer. I understand services provided, with a referral, may be covered by my health plan or insurer.

I have informed my therapist of any condition that would limit my ability to have and evaluation or to be treated. I have read the above information and hereby request and consent to the evaluation and treatment to be provided by the therapists of Marina D. Castellanos PT, PLLC

Date_____ Patient Name: _____
(Please Print)

_____ _____
Patient Signature Signature of Parent or Guardian (If applicable)

_____
Witness Signature