PAWEL WAWRZYNIAK
PT - DPT - SCS

CONDITIONS & CONSENT FOR PHYSICAL THERAPY

1. COOPERATION WITH TREATMENT: I understand that in order for physical therapy to be effective, I must present myself as scheduled unless there is an unusual circumstance that prevents me from attending therapy. I understand that I may be discharged from physical therapy if I do not keep three (3) appointments without calling to cancel or reschedule. I agree to cooperate with the home program assigned to me. If I have difficulty, I will discuss it with my therapist.
2. NO WARRANTY: The physical therapy department does not promise a cure for my condition. The staff will share with me the available statistics and studies regarding results of physical therapy treatment for my condition. They will discuss all treatment options with me.
3. INFORMED CONSENT TO TREATMENT: In accordance with New York State Public Health Law section 2782, informed consent means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to me. The department provides a wide scope of services, and I will receive information at the initial visit on the treatment/assessment options available for my condition. Potential risks include an increase in my current level of pain or discomfort, or an aggravation of my existing injury. This discomfort is temporary and will probably subside in 24 hours. Potential benefits include 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 will have greater knowledge on managing my condition and the resources available to me. Alternatives to physical therapy treatment will be explained to me. If I do not wish to participate in the therapy program, I may discuss my medical, surgical, or pharmacological alternatives with my physician.
4. CONSENT TO HIV TESTING: In the event anyone in our staff should become exposed to fluids that may transmit HIV during my care, I will be deemed to have consented to the practice's right to draw blood for testing of HIV, as well as to the release of such results to the practice and to the individual who suffered the exposure, in accordance with New York State Public Health Law section 2782. I have read or had read to me the foregoing and any questions that may have occurred to me have been answered to my satisfaction. I understand the risks, benefits, and alternatives of the treatment. Based on the information I have received from the therapist; I voluntarily consent to physical therapy treatment. I understand that I may withdraw at any time.

PATIENT'S SIGNATURE _____ DATE _____
PATIENT'S LEGAL REPRESENTATIVE/ GUARDIAN / PARENT _____
RELATIONSHIP TO PATIENT _____
THERAPIST'S SIGNATURE _____DATE_____