Consent to Physiotherapy Assessment and Treatment

This is to acknowledge that the patient consents to an assessment and treatment and as a patient of Kate Devine, PT, has been informed of the following:

• Patients are free to withdraw consent, in whole or in part, at any time;
• Assessment and treatment for *pelvic floor disorders* involves evaluation of the pelvic floor muscles through internal manual palpation (a vaginal and/or rectal examination);
• Physiotherapy treatments may include, but are not limited to, manual therapy, exercise prescription, modalities such as ultrasound and interferential current, neuromuscular electrical stimulation, acupuncture, cupping, and EMG biofeedback;
• Kate Devine, PT, will endeavour to provide the best possible diagnosis and provide evidence-based treatment, but no guarantee has been made with respect to any treatment, action, or advice given. Patients will receive information about their diagnosis and/or treatment, expected benefits, risks, side effects, and/or alternative courses of action;
• A health record will be kept on each patient. It is confidential and is not released without patient consent unless required by law.

Reports:
Would you like a report sent to your doctor or other referral source?
     No ☐
     Yes ☐   send an assessment report to: _____

Fee Policy
Patients are responsible for the fees incurred during care and treatments.
Physiotherapy appointments are not covered by provincial health care (MSI) but are often covered by private health insurance and direct billing is available.

Cancellation Policy
Cancellations made without 24 hrs' notice or missed appointments will be charged 50%.

Newsletter
Do you consent to periodic clinic updates and newsletters emailed to you?
Yes _____ or No _____

I, _____, have read, agree to, and understand the above declaration. I give my informed consent to Kate Devine, PT, to provide physiotherapy consultation, assessment, and/or treatment to me. I intend this informed consent to apply to all my present and future physiotherapy care.

Signature of Patient (Parent/Guardian, if applicable): _____

Date: _____

Witness: _____