Movement Chiropractic
7-3602 Taylor Street East
Saskatoon, SK S7H 5H9

INFORMED CONSENT TO PHYSICAL THERAPY TREATMENT

Please read the following statements and sign below if you are in agreement.

I will inform the physical therapist of any contagious or infectious conditions that I may have.

I understand that I need to express all my health concerns, both present and past to my therapist.

I consent to being examined and treated by the physical therapist. I understand that my treatment in this clinic may involve the use of various physical and electrical modalities, mobilization or manipulation of joints and tissues, as well as exercise programs aimed at mobility, strength and function.

I understand that soreness after treatment may occur when my joints and tissues are stretched, mobilized, manipulated or exercised. The therapist will contact my physician should the presence of these symptoms represent any potential risks. I understand that it is my responsibility to contact an employee of the clinic should I experience any unusual symptoms.

I agree to pay for all services provided as they occur.

Twenty-four hours' notice is required if you wish to cancel or change your appointment. If no notice or late notice is given, you will be subject to a $25.00 charge.

I agree to ask for clarification should I have any questions or concerns.

My signature below indicates my understanding of the above information.

_____ **X**_____
PATIENT NAME (Printed) PATIENT (or Guardian) SIGNATURE

_____ _____
WITNESS DATE