# Patient Consent to Treatment Form

**Starr Spine Physical Therapy and Wellness, LLC**

3966 First St Unit A; Grove City, OH 43123 (614) 594-2400

Physical Therapy is a patient care service that is provided in order to manage and treat a wide variety if conditions. Services are provided to individuals of all ages regardless of gender, ethnicity, creed, national origin, or disability.

The purpose of physical therapy is to treat, mitigate, or prevent medical conditions, injury and functional impairments through examination, evaluation, diagnosis, prognosis and intervention by use of rehabilitative procedures, such as mobilization of joints and soft tissue, exercises, patient education and modalities. Treatments are designed to help patients individually reach their greatest potential within their capabilities and to expedite healing and reduce the length of functional recovery or dysfunction.

All procedures will be explained thoroughly to you as needed and requested before you are asked to perform or participate in them. You have the right to ask questions to understand all treatments/procedures so that you may understand the purpose, risks, and benefits before consenting to them. Each patient responds differently to any given treatment. Hence, it is not possible to accurately predict your response to physical therapy as it is not an exact science. Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury. It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. Starr Spine Physical Therapy and Wellness, LLC does not guarantee successful completion or the results of the treatment provided.

I have read this consent form and understand the potential risks involved in physical therapy and my responsibility. I understand that the success of my treatment depends on my ability and willingness to cooperate and participate in all physical therapy procedures and comply with the established plan of care per collaboration with my physical therapist. I consent to receive treatment at Starr Spine Physical Therapy and Wellness, LLC.

Patient or Legal Guardian Signature:_______________________________________________________________

Patient Name (and Legal Guardian if applicable)__________________________________ Date:____________