SPRINGER
—PHYSICAL THERAPY—

INFORMED CONSENT FOR INTERNAL ASSESSMENT, EVALUATION, AND TREATMENT OF PELVIC FLOOR DYSFUNCTION

Treatment: I consent to internal assessment evaluation and treatment of pelvic floor dysfunction. The potential risks, benefits and alternatives of therapy, evaluation and treatment have been explained to me. I understand that the therapist provides a wide range of services and that I will receive information at the initial visit concerning the evaluation, treatment, and options available for my condition.

I 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 or pain with bowel, bladder or sexual functions, painful scars after childbirth or surgery, persistent sacroiliac or low back pain, or pelvic pain conditions.

I acknowledge and understand that to evaluate my condition, it may be necessary, initially and periodically, to have my therapist perform an internal pelvic floor muscle examination. This examination is performed by observing and/or palpating the perineal region, including the vagina and/or rectum. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, scar mobility, and function of the pelvic floor region. Such evaluation may include vaginal or rectal sensors for muscle biofeedback.

I agree to inform my therapist of any condition that may limit my ability to have an evaluation or be treated including but not limited to: pregnancy, infection, vaginal dryness, less than 6 weeks postpartum or post-surgery, severe pelvic pain, sensitivity to latex, vaginal creams or KY jelly.

I acknowledge and understand that treatment may include, but is not limited to, the following: observation, palpation, use of vaginal weights, vaginal or rectal sensors for biofeedback and/or electrical stimulation, ultrasound, heat, cold, stretching and strengthening exercises, soft tissue and/or joint mobilization, and educational instruction. I understand that if I am uncomfortable with the assessment or treatment procedures at any time, I will inform the physical therapist and the procedure will be discontinued and alternatives will be discussed with me.

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

Potential Benefits: May 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 or 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.

Cooperation with Treatment: I understand that in order for therapy to be effective, I must attend as scheduled unless there are unusual circumstances that prevent me from attending therapy. I agree to cooperate with and carry out the home 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 $30.00 or $60.00 depending on the length of the scheduled appointment.

Financial Responsibility: I am aware that internal and/or external sensors may be indicated as part of my treatment and that my insurance may cover the external sensors used with the Biofeedback however does not pay for my healthcare costs related to the internal sensor. I acknowledge some insurance plans exclude or limit these services based upon their individual program standards. I am aware that my therapist will make an effort to use the external sensor however it may be deemed medically necessary to use the internal sensor for my care. I acknowledge that I have been informed of the cost and possible need to the internal sensor and that I will have to pay for the sensor up front before knowing if it will be covered by my health insurance plan.

No Warranty: I understand that the physical therapist cannot make any promises or guarantees regarding a cure for, or improvement in, my condition.

I have read or had read to me the foregoing and all questions have been answered to my satisfaction. I understand the risks, benefits, and alternatives of the treatment and I hereby request and consent to the assessment, evaluation and treatment of pelvic floor dysfunction.

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Patient's Name (Please print)	Signature of Patient or Legally Authorized Person	Date