BIHC | Belleville Integrative Health Centre
WORKING TOGETHER FOR YOUR HEALTH

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Consent to Physiotherapy Treatment

I hereby consent to physiotherapy treatment which may include but is not limited to the following: manual therapy, exercise, education, electrical modalities, heat and cold therapy.
I have been told about the following:

- what the treatment is
- who will be providing the treatment
- the reasons why I should have the treatment
- the alternatives to having the treatment
- the important effects, risks, and side-effects of the treatment
- what would happen if I do not have the treatment

I understand the explanation and have no further questions. My consent is voluntary.

Date: _____Signature of Patient: _____
(or parent/guardian)

Date: _____Signature of Witness: _____

Consent for the Cost of Services

I understand that I am responsible to pay the fees for physiotherapy care I receive at each session. Fees are due at the end of your appointment once services are rendered. If treatment is billed as an insurance claim and your claim is denied, you will be responsible for payment for all services rendered.

Pelvic Floor Assessment	$130.00
Standard Pelvic Floor Follow up	$90.00
Complex Pelvic Floor Follow up	$95.00
MSK Assessment	$80.00
MSK Follow up	$80.00

There is a $40.00 fee for missing any appointment without notifying our office 24 hours prior to appointment time. Payment of this fee will be due at your next appointment.

Date: _____ Signature of Patient: _____
(or parent/guardian)
Date: _____Signature of Witness: _____

PELVIC FLOOR CONSENT FOR EVALUATION AND TREATMENT

I acknowledge and understand that I am attending physiotherapy for evaluation and treatment of pelvic floor dysfunction. Pelvic floor dysfunctions include, but are not limited to, urinary or fecal incontinence; difficulty with bowel, bladder, or sexual functions; painful scars after childbirth or surgery; persistent sacroiliac or low back pain; or pelvic pain conditions.

I 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.

Treatment may include, but not be 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 in order for therapy to be effective, I must come 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.

1. The purpose, risks, and benefits of this evaluation have been explained to me.
2. I understand that I can terminate the procedure at any time.
3. I understand that I am responsible for immediately telling the examiner if I am having any discomfort or unusual symptoms during the evaluation.
4. I have the option of having a second person present in the room during the procedure

Patient Name (Printed) _____

Date: _____ Signature of Patient: _____
(or parent/guardian)

Date: _____Signature of Witness: _____