

Schertz Parkway Physical Therapy Consent to Treat

I _____ hereby request and consent to Schertz Parkway Physical Therapy to perform rehabilitative treatment and care as prescribed by my physician and/or recommended by my physical therapist.

I understand and am informed that, as in the practice of medicine, physical therapy may have some risks. I understand that I have the right to ask about these risks and have any questions answered about my condition, prior to treatment.

I authorize the physical therapist to perform any additional or different treatment, which is deemed necessary should, during treatment, a condition be discovered which was not known previously.

I have carefully read and fully understand this Informed Consent Form and have had the opportunity to discuss my condition with the treating physical therapist.

I consent and authorize Schertz Parkway Physical Therapy, PLLC (including students in training) to administer treatment under the direction and supervision of the physical therapist.

Signature of Patient Date

Signature of Parent/Legal Guardian (to minor) Relationship to Patient