PELVIC HEALTH CONSENT FORM

Pelvic Health Consent for Consultation, Evaluation & Treatment

In consideration of participating in pelvic floor physical therapy evaluation and treatment ("activity") and/or receiving any pelvic floor physical therapy–related education/information ("information") via consultation I acknowledge & understand that:

____ *(initials)* I have been informed and educated about the purpose and nature of pelvic floor physical therapy activities and information. I understand that 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.

____ *(initials)* 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.

____ *(initials)* activities may include, but are not limited to, the following: observation, palpation, use of vaginal weights, stretching and strengthening exercises, soft tissue and/or joint mobilization, and educational instruction.
in order for therapy to be effective, I must participate during all scheduled sessions unless there are unusual circumstances that prevent me from doing so. 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.

____ *(initials)* any information given or findings from any and all pelvic floor physical therapy activities are intended to be used for educational purposes only and are not designed to replace the care or advice of any medical provider. If I have any known pathological urological, gynecological, colorectal, gastrointestinal and/or musculoskeletal condition, fall into certain high risk categories, and/or if any part of the screening reproduces any symptoms related to said known condition(s), I should promptly consult with a physician and obtain their approval prior to engaging in further pelvic health physical therapy treatment or lifestyle change activity. Quozette Valera/DRQDPT is not liable for any health consequences resulting from my participation in any activity or consultation, and is not responsible for ensuring that I have consulted with my physician regarding any recommendations I may receive as a result of said participation, nor will any results be automatically sent to a healthcare provider on my behalf.

____ *(initials)*

1. The purpose, risks and benefits of this evaluation have been explained to me.
2. I understand that I can decline to receive any internal evaluation and/or specified treatment(s).
3. I understand that it is my right to terminate any treatment or activity at any time.
4. I understand that I am responsible for immediately telling the examiner if I am having any discomfort or unusual symptoms during the evaluation.
5. I have the option of having a second person present in the room during any internal evaluation or treatment & I:
   - ☐ choose the option to have a chaperone present
   - ☐ decline the option to have a chaperone present

________________________ CLIENT'S NAME (PRINT)

________________________ CLIENT'S SIGNATURE

__________ DATE

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