Patient Name:_____ DOB:_____

Informed Consent for Treatment

I (we) voluntarily consent and authorize Minnesota Therapy & Balance Center LLC, its physical therapists, physical therapy assistants, and other health care providers as they may deem necessary, to perform an evaluation, give advice, and to provide treatments/ procedures for my condition which has been explained to me. I (we) understand that my physical therapist may discover other or different conditions which require additional or different procedures than those planned and may require consent from my physician before such additional or different procedures are utilized. I (we) authorize Minnesota Therapy & Balance Center LLC, its physical therapists, physical therapy assistants, and other health care providers as they may deem necessary with consent from my physician to perform such other procedures which are advisable in their professional judgment.

I (we) understand that no warranty or guarantee has been made to me as to result or cure. Just as there may be risks and hazards in continuing my present condition without treatment, there is a potential risk, although rare, of side effects related to the performance of the physical therapy evaluation and treatment/ procedures planned for me.

I have read the foregoing and I understand it. I consent to a physical therapy evaluation, advice, and treatment/ procedures as prescribed by my provider or through self referral (direct access).

Patient/Guardian Signature:_____ Date: _____