DEPARTMENT OF REHABILITATION

Phone (910)577-2372 ● Fax (910)577-2625

Outpatient Services
Consent for Treatment

I have received the Rehabilitation Services informational brochure, understand the information presented and agree to abide by the guidelines.

I consent to:

- an evaluation by a licensed therapist.
- treatment as deemed appropriate by the therapist with ongoing consultation with my referring physician.
- the use of photographs for documentation purposes.

I understand that:

- treatment may include exercise, manual therapy, thermal and electrical modalities in addition to a variety of specialized treatments that will be explained to me by my therapist.
- it is my responsibility to inform my therapist if I am pregnant, if there have been any changes in my medical condition, or if my minor child is pregnant.
- it is my responsibility to report changes in my medical insurance.
- I may ask questions at any time and that I may decline treatment.
- I may have the opportunity to be visited and/or assisted by a therapy dog during my treatment(s) (please initial)_____ Agreed _____Declined

I understand that I am responsible for scheduling and attending my appointments as recommended by the therapist and my doctor and confirm that I have received a copy of the attendance policy.

I understand that it is my responsibility to be aware of my insurance coverage, and the number of visits allowed for current or future treatments.

____
Signature of Patient (or guardian)

____
Witness

____
Date

CNS

OP Consent

317 Western Boulevard
Jacksonville, NC 28546