



BRANDE MOFFATT, MPT, PRTC

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CONSENT TO TREAT (TELEHEALTH)

____ I hereby consent, by my own free will, to voluntarily engage in the virtual/ tele-health session, through telephone or video conferencing (Doxy.me)

____ I hereby consent to the evaluation and treatment of my condition by a licensed physical therapist (Brande Moffatt, MPT, PRTC). I understand that the physical therapist will explain the nature and purposes of these procedures, evaluation, and course of treatment.

____ I understand that recommendations will be made by my therapist, based on the findings in this session, for improvement of my pain and overall wellness. I understand that I may be directed through specific activities, exercises and/ or movements as instructed by my therapist. I am aware that my physical therapist will inform me of expected benefits and complications, and any discomforts, and risk that may arise, as well as alternatives to the proposed treatment and the risk and consequences of no treatment.

____ I have been informed and understand that during my participation in any sessions, I will be responsible for honestly reporting any symptoms I may have, such as pain, fatigue, shortness of breath, or ANY other findings.

____ I know that it is my right to stop any activity at any time, during any session, as well as it being my obligation to inform the therapist of any symptoms, should any develop (as indicated above).

____ I understand that my therapist will make every effort to address my symptoms, functional deficits (if any) and concerns and that the goal is for total alleviation of symptoms and/or improvement of function. Even with the best program there is a possibility that I may not notice changes or improvements.

____ I recognize that these sessions will allow me to learn ways to move better, feel better and teach me techniques and skills that I can utilize independently on a daily basis and improve my quality of life.

____ I am aware that addressing my symptoms or diagnosis may take a few sessions and I am required to closely follow all provided instruction to ensure improvements within at least 4-6 sessions (if not sooner).

____ I understand that the number of sessions will vary based on the primary complaints and symptoms and that this reference serves as an average and not a definite number.

____ I understand that I am 100% responsible for payment, due at time of scheduling. If so desired, we will courtesy bill your insurance for you, and you will be reimbursed by your insurance company any monies due back to you for out of network benefits, although there is no guarantee of payment. If you opt for private pay/NO insurance in any form will be billed, charged or collected for these sessions. I choose by my own free will to participate and invest in this service.

____ In taking part in these sessions, via phone or video platform, I acknowledge that I am fully responsible for any and all risks, injuries, or damages, known or unknown, which might occur as a result of my participation. By signing below, I hereby WAIVE AND RELEASE (Brande Moffatt, MPT, DBA, Women's Health Physical Therapy from any claim, demand, cause of action of any kind resulting from or related to my participation in the online/ telehealth sessions.

Patient Name: _____ Date: _____

Patient Signature: _____