

Ultimate Therapy
40900 Merchants Lane, Suite 202
Leonardtown, MD 20650

General Consent for Evaluation and Treatment

I acknowledge and understand that I have been referred to Ultimate Therapy for evaluation and treatment of Pelvic Floor Dysfunction. I understand that to evaluate my condition it may be necessary, initially and periodically, to have my physical therapist perform an internal pelvic floor muscle exam to assess strength, range of motion, scar mobility and muscle length. Such evaluation and treatment may include, but not be limited to, the following: observation, palpation, use of vaginal cones, vaginal or rectal sensors for biofeedback and/or electrical stimulation, exercise, soft tissue mobilization, education, instruction and neuromuscular techniques of the perineal area. Treatment may also include joint mobilization, modalities such as ultrasound and electrical stimulation, iontophoresis, etc.

I understand that no guarantees have been or can be provided regarding the success of therapy. I hereby request and consents to the evaluation and treatment to be provided by the physical therapists and physical therapy assistants of Ultimate Therapy.

Patient Name: _____ Date: _____

Patient Signature: _____