COX PHYSICAL THERAPY
PELVIC HEALTH::CHRONIC PAIN
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INFORMED CONSENT

CONDITIONS OF AND CONSENT FOR TREATMENT:

I hereby request and authorize **Cox Physical Therapy** (herein referred to as CPT) to perform therapy on me. I understand that my therapy includes manual hands on therapy of the soft tissues and other structures of the head, neck, arms, chest, trunk, abdomen, lower back, hips and legs, pelvis, urogenital organs, and any area believed to be related to my condition. I consent to treatment which will include external and possible internal vaginal and/or rectal assessment and treatment (if pelvic internal work is indicated). I understand internal work may be necessary in order to access certain ligaments, muscles, structures, joints, adhesions and fibrotic tissue which may be affecting my condition. I understand I may refuse any suggested treatment at any time. I will be treated in a private treatment room; CPT follows ethical guidelines of American Medical Association (AMA) and American College of Obstetrics and Gynecology (ACOG) regarding patient draping and right to chaperone. I will always have access to draping, blanket, sheets and/or towels.

POTENTIAL SIDE EFFECTS:

For most patients, side effects from this treatment have been transient and minimal, such as temporary minor soreness of the treated areas, soreness in other areas of the body following treatment, possible spotting for women after internal treatment. Patients with soreness have found relief with ice, over-the-counter anti-inflammatory medication (e.g. ibuprofen) or Epsom Salt baths. I understand, for some patients (due to inflammation, prior trauma, etc.) therapy may cause discomfort, mild pain or emotional distress, but significant pain or emotional distress are rare. Since treatment may exacerbate an active infection, I agree to notify my therapist(s) if I contract an infection. Therapy will be discontinued temporarily pending medical clearance to continue. If I receive a test or diagnosis showing an infection or acute flare-up before therapy, I will consult a CPT before I attend.

I agree to remain attentive to my condition and notify my therapist immediately if I experience any of the following: severe abdominal pain, persistent bleeding, fainting, dizziness, lightheadedness, or shortness of breath, accompanied by weakness, loss of color, or severe abdominal pain, fever, nausea or vomiting. Should these persist, I will seek emergency medical help to rule out serious or life-threatening conditions.

WISH TO UNDERGO TREATMENT:

Having been advised and having the general understanding of the treatment procedure and the potential risks involved, under all the surrounding circumstances, I wish to undergo the procedure above-described.

I CERTIFY THAT I HAVE READ THE CONTENTS OF THIS DOCUMENT.

Patient signature:____date: _________________________