

TAPPAN PHYSICAL THERAPY  
6 Schreiber Street  
Tappan, NY 10983  
845-365-0865

Informed Consent for Physical Therapy Services During COVID-19

In order to maintain the highest level of safety for patients and staff during the COVID-19 pandemic, extra care has been taken to follow all sanitizing and social distancing rules. If you have any questions or concerns about our COVID-19 office protocol, please do not hesitate to let us know.

In general, physical therapy is a patient care service that is provided in order to manage a wide variety of conditions. The purpose of physical therapy is to treat disease, injury and disability by examination and intervention by use of rehabilitative procedures that include massage, joint mobilization exercises and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. All procedures will be thoroughly explained to you before they are performed. Response to physical therapy varies from person to person. Hence, it is not possible to accurately predict your response to treatment. Tappan Physical Therapy does not guarantee what your reaction will be to a specific procedure, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury. It is your right to decline any part of your treatment at any time before or during a session, should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your in-office treatment.

I have read this consent form and understand that the risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures and comply with the established plan of care. I authorize release of my medical information to appropriate third parties.

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Patient Signature \_\_\_\_\_