



**Denise Alberto Physical Therapy**  
15055 Los Gatos Blvd., Ste. 250  
Los Gatos, CA 95032

**CONDITIONS & CONSENT FOR PHYSICAL THERAPY**

I understand that I am a patient of Denise Alberto, MPT who is an independent Physical Therapy practitioner at Denise Alberto Physical Therapy. My care is the exclusive responsibility of Denise Alberto, MPT not of any other practitioners who also may practice at this location.

**Cooperation with treatment:**

In order for physical therapy treatment to be effective, I must come to scheduled appointments unless there are unusual circumstances. I understand and agree to cooperate with and perform the home physical therapy program intended for me. If I have trouble with any part of my treatment program, I will discuss it with my therapist.

**Cancellation Policy**

I understand that if I cancel more than 24 hours in advance, I will not be charged. I understand that if I cancel less than 24 hours in advance, I will pay a cancellation fee of \$ 75.00. To be paid at the time of your next appointment.

**No warranty:** I understand that there are no guarantees regarding a cure for or improvement in my condition. I understand that my physical therapist will outline and discuss goals of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

**Informed consent for treatment:**

The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to you. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition.

**Potential risks:** I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury or condition. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my physical therapist.

**Potential benefits:** I may include an improvement in my symptoms and an increase in my ability to perform daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

**Alternatives:** If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

**Release of medical records:**

I authorize the release of my medical records to the following physicians/primary care provider or insurance company;

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**Financial and insurance responsibilities:**

I agree to pay for my treatments at time of service, by cash, check, or MasterCard/VISA unless other mutually agreed upon arrangements have been made. I understand it is my responsibility to call my insurance company ahead of time, and obtain any pre-authorization that is necessary, and get an estimate of my benefits. I understand my therapist will provide me with a receipt on the same day of service that is my responsibility to submit to my insurance company.

**I have read the above information and I consent to physical therapy evaluation and treatment.**

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient or Parent/Guardian Signature

\_\_\_\_\_  
Therapists Signature and Date



## **PELVIC FLOOR CONSENT FOR EVALUATION AND TREATMENT**

I acknowledge and understand that I have been referred to Denise Alberto, Physical Therapist 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, and internal vaginal or rectal massage to the pelvic floor muscles.

I understand that no guarantees have been or can be provided regarding the success of therapy. I hereby request and consent to the evaluation and treatment to be provided by Denise Alberto, P.T..

Date \_\_\_\_\_

\_\_\_\_\_  
Patient Name: (Please Print)

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

\_\_\_\_\_  
Signature of Parent or Guardian (if applicable)