AC Physical Therapy

PELVIC FLOOR CONSENT FOR EVALUATION AND TREATMENT

I acknowledge and understand that I have been referred to AC Physical 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 tension. 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. Evaluation procedures will be discussed and verbal consent will also be gained prior. I hereby request and consent to the evaluation and treatment to be provided by Amber Carpenter, M.P.T.

Date_________________

Patient Name: (Please Print)______________________

Patient Signature:____________________________

Signature of Parent or Guardian (if applicable):________________________________