CARPENTER
Physical Therapy

INFORMED CONSENT FOR MYOFASCIAL RELEASE SERVICES

I,_____, acknowledge that **CARPENTER PHYSICAL THERAPY, PLLC.**, through its owners, agents, or employees, will provide my myofascial release as physical therapy services ("P.T. Myofascial Services").

I further acknowledge that:

- ✓ The PT Myofascial Services, plan of treatment, and material risks will be explained to me and I can discuss any concerns with the practice, healthcare provider, or treatment plan at any time during my care.

- ✓ The therapists at **CARPENTER PHYSICAL THERAPY, PLLC**., must provide Myofascial Release services in accordance with NY State Physical Therapy Practice Act, which will require a referral from my medical provider for "Myofascial Release" services within 30 days of start.

- ✓ The Myofascial Release services provided are considered preventative and therefore, are not covered by insurance payers.

- ✓ These Myofascial services may not have the results I expect.

- ✓ Myofascial release and PT services are not exact sciences. I have not been given any guarantees about results.

- ✓ By signing below, I hereby provide my informed consent to receive Myofascial Services at **CARPENTER PHYSICAL THERAPY, PLLC.**

_____ _____

Signature Date