Key Therapeutics, LLC

CONSENT TO PHYSICAL THERAPY TREATMENT

Fascial Counterstrain Treatment Description and Patient Rights:

Fascial Counterstrain (FCS) is a gentle, manual, treatment technique that identifies and alleviates fascial restrictions in the body. Utilizing light hands-on contact, anatomical structures are identified, slackened and held for 30-40 seconds in order to alleviate pain, reduce swelling, improve circulation, increase range of motion and restore pain free function. The cranium (head) is used to identify specific restrictions in the body. Depending on the structures targeted, contact may involve the chest wall (through breast tissue), abdomen, pelvis, pelvic floor and/or buttocks. On some occasions patients report diffuse soreness, an increase in pain or a shifting of pain following treatment. I understand this is a normal result of treatment as swelling and inflammation are released from the body.

I have the right to refuse FCS treatment to any area of the body. If I am uncomfortable with any aspect of treatment, I will advise my attending therapist in advance of my treatment so that the treatment session may be modified or so that I may be referred for alternative treatment. Refusal of treatment on a specific area will not terminate or affect my relationship with Key Therapeutics, LLC Physical Therapy.

General Consent:

By signing below, I hereby consent to evaluation and treatment of my condition by Karen Andrews, PT, MTC, CSC1 (a physical therapist licensed in the State of Maryland). I understand the expected benefits, alternatives and possible risks of discomfort, which may result from any form of physical therapy, including FCS treatment.

I acknowledge and understand that there is no guarantee that the proposed course of treatment will improve my condition. If any post treatment discomfort does not subside in 1-3 days, I agree to contact my attending therapist for the purpose of re-evaluation, medical referral or a change in plan of care.

By signing below, I acknowledge that I have read and understand the above language of this "Consent to Physical Therapy Treatment" and that the benefits and risks of physical therapy (FCS) have been explained to me. Effective on the date below, and continuing until I revoke this document in writing, I hereby consent to Physical Therapy treatment including Fascial Counterstrain. I agree to update my medical status or condition, with any changes that may affect my treatment. If, at any time, I elect to modify or terminate treatment, I may do so by notifying my attending therapist.

Please indicate if you have a history of trauma which will assist your therapist in providing the utmost care during your treatment . Yes _____ No _____

PATIENT NAME: (please print) _____

PATIENT RELATIONSHIP: _____

AUTHORIZED SIGNATURE : _____

DATE: _____