**Cambridge Physiotherapy & Rehab Center**

**Patient Information**

|  |  |
| --- | --- |
| **Patient Name:** |  |
| **Date of Birth:** |  |
| **Address:** |  |
| **Emergency Contact:** | Name:Phone:Relationship: |
|  **Email Address:**  |  |
| **Family Doctor** |  |
| **How did you hear about our Clinic?** |  |

**Scoliosis Therapy Consent**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ do hereby consent to the assessment & ongoing treatment for Scoliosis Treatment at Cambridge Physiotherapy & Rehab Center. My service provider will be those that work in the above mentioned establishment to whom I authorize the review of my personal medical records and permission to communicate or consult to other healthcare professionals with relevant information, as it applies to my rehabilitation process. I have been told of any alternative services available and any changes made in my service(s) will be discussed with me before they are made. I am aware of any, or all, risks involved during the assessment & treatment session(s) and understand that results are not guaranteed.

I authorize treatment(s) to be administered by appropriate Physiotherapist. I intend this consent form to cover the entire course of my treatment program.

**Patient Signature:**

**Parent or Guardian Signature:**

(If patient is under the age of 18)

**Witness: Today’s Date:**

Mm/dd/year