



**Patient's Informed Consent**

I, \_\_\_\_\_, the undersigned, acknowledge that I have agreed to participate in the plan of care for the treatment of the condition for which I was referred by my physician to restore acceptable levels of functional ability.

I understand that the treatment may consist of a variety of therapeutic procedures including, but not limited to; manual therapy, therapeutic exercises (including progressive resistance exercise and aerobic activity), electrical stimulation, ultrasound, muscle testing, functional activities, traction, vasopneumatic devices, and others forms of intervention appropriate for my condition.

I also understand that I have the right to discontinue and/or refuse treatment at any given time. I will not hold the licensed and support staff of The Centers for Advanced Orthopaedics, Potomac Valley Sports Medicine Division, liable in the event I discontinue and/or refuse care during the course of my treatment plan.

I am aware of and agree to the **Cancellation and No Show Policy**, which states all appointments must be cancelled at least 2 hours prior to your appointment time or a \$30.00 fee will be issued.

In light of this information, I agreed to be treated and supervised by the licensed and support staff of The Centers for Advanced Orthopaedics, Potomac Valley Sports Medicine Division.

\_\_\_\_\_  
Patient's Signature

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Parent of Legal Guardian if under 18

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