The Centers for Advanced Orthopaedics
POTOMAC VALLEY SPORTS MEDICINE

# 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 Orthopaedics 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 24 hours prior to your appointment time or a $35.00 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 Orthopaedics Division.

_____ ___/___/___
Patient's Signature

_____ ___/___/___
Parent of Legal Guardian if under 18