

# INFORMED CONSENT TO PARTICIPATE IN ACTIVE REHABILITATION

7-60

## THE GOALS OF THE REHABILITATION PROGRAM INCLUDE:

1. Determining the cause and extent of your problem.
2. Providing a therapeutic exercise program to strengthen you, increase your cardiovascular endurance, range of motion and flexibility, and decrease your pain.
3. Return you to full-duty, non-restricted work status and lifestyle.

THE EQUIPMENT USED TO TEST YOU AND THE PROCESS WE WILL BE USING WILL BE EXPLAINED TO YOU.

Your participation in the rehabilitation program is voluntary. You can stop at any point in the program. Should you stop your program, we are obligated to notify your doctor, insurance company, attorney, and DVR manager, if it is applicable.

If at any point during the evaluation or rehabilitation process you have any questions, we will answer them to the best of our ability or refer you to someone more qualified. Please be advised that there are no guarantees that your personal goals and/or those listed above will be met to your satisfaction. The success of any rehabilitation process lies in the combined efforts of you and your provider. The "team" approach has the best chance of attaining your goals, so please ask as many questions as necessary for you to gain the maximum benefit from your rehabilitation program.

Since the process of strengthening and conditioning are a form of "controlled strain", there is a chance of aggravation or injury. It is therefore imperative that you communicate to your provider any aggravation or injury that you may observe during the rehabilitation process. For example, the best exercise for you, if performed too early in your condition, may be your worst enemy if performed too soon. Communication with your provider will help put into perspective problems that may occur. Failure to discuss problems may only foster additional problems down the road.

I HAVE READ THE ABOVE AND UNDERSTAND THE RISKS AND BENEFITS OF THE REHABILITATION PROGRAM. I AGREE TO PARTICIPATE AND HAVE MY REHABILITATION INFORMATION RELEASED TO MY DOCTOR, INSURANCE CARRIER, ATTORNEY, OR DVR PERSONNEL IF REQUESTED.

DATE \_\_\_\_\_

SIGNATURE OF PARTICIPANT \_\_\_\_\_

DATE \_\_\_\_\_

SIGNATURE OF WITNESS \_\_\_\_\_

RESEARCH CONCERNING THE REHABILITATION PROGRAM AND RESULTS MAY BE CONDUCTED. DATA WILL BE USED FROM THE PARTICIPANT'S EVALUATIONS AND EXERCISE PROGRAM. NO NAMES WILL BE USED AND ALL INFORMATION IS STRICTLY CONFIDENTIAL. PLEASE INITIAL BELOW.

\_\_\_\_ I AGREE TO PARTICIPATE

\_\_\_\_ I DO NOT WISH TO PARTICIPATE