

Consent form

Physiotherapy

Business name

CLIENT DETAILS

Full name

Phone number

Email

Date of birth

I CONFIRM THAT

- ☐ I have shared accurate information about my health and medication.
- ☐ The treatment plan, its expected benefits and possible discomfort were explained to me.
- ☐ I can stop the treatment at any time.
- ☐ I will tell the therapist about any change in my condition.

I agree that the business keeps the information in this form to provide the service and for as long as the law requires. I can ask to see, correct or delete my data at any time.

Client signature

Specialist signature

Date
