

AlignedPosture Informed Consent Form

Client Information:

Full Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

Email Address: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____

Provider Information:

Therapist/Consultant Name: _____

Practice Name: _____

Contact Information: _____

Introduction and Purpose of Therapy

At AlignedPosture we have a specialised approach that focuses on improving postural alignment through corrective exercises, drills, and techniques. The goal is to address any muscular imbalances or dysfunctions that may be affecting posture, movement, or overall physical function. These techniques are designed to help the body function more efficiently and reduce discomfort or strain.

As part of your therapy plan, you will be performing specific exercises and drills that aim to restore balance and improve your posture. These may involve activities that challenge or engage specific muscle groups to promote proper alignment.

Nature of the Treatment

1. **Description of Treatment:** You will participate in specific postural restoration exercises, drills, and therapies that may include stretching, strengthening, breathing exercises, and positional adjustments. These techniques are designed to improve your posture and correct any imbalances identified in your musculoskeletal system.

2. **Expected Outcomes:** Improved posture, increased flexibility, reduced discomfort, and enhanced physical performance are the main goals of the therapy. However, individual results may vary, and it is not guaranteed that you will experience complete resolution of any musculoskeletal issues.

3. **Possible Side Effects or Discomfort:** You may experience some initial soreness or mild discomfort following therapy, as your body adjusts to new movements or postural changes. This is typical and should subside with time. However, if any pain or discomfort is severe or prolonged, you should notify your therapist immediately.

4. **Duration and Frequency of Sessions:** Your therapy plan will include an individualised approach, which may require a series of sessions over a specified period. Your therapist will work with you to ensure the therapy is progressing appropriately for your needs.

Confidentiality and Privacy

Your personal health information and treatment records will remain confidential and will not be shared with others without your written consent, except as required by law or professional ethics. You have the right to request a copy of your records or to discuss them with your therapist at any time.

Risks and Benefits

Risks: While postural therapies are generally safe, there are inherent risks in any form of physical therapy. These risks may include discomfort, muscle fatigue, or temporary increases in pain during the treatment process.

Benefits: Potential benefits of postural therapy include improved posture, enhanced mobility, better physical function, and the reduction of musculoskeletal pain or discomfort.

Client Responsibilities

By signing this consent form, you acknowledge that you are responsible for:

1. Communicating openly with your therapist about any existing medical conditions, previous injuries, or health concerns that may affect your participation in therapy.
2. Following the prescribed home exercises or activities as directed by your therapist.
3. Reporting any discomfort, pain, or concerns during therapy sessions or after completing exercises at home.

Right to Withdraw Consent

You have the right to withdraw your consent and discontinue therapy at any time without penalty. Should you choose to stop therapy, please inform your therapist immediately.

Acknowledgment of Understanding and Consent

I, the undersigned, have read and understand the information provided above. I understand the nature and purpose of the therapy, the potential risks and benefits, and my role in the process. I consent to participate in the prescribed posture and movement restoration and agree to follow the guidance of my therapist to the best of my ability.

I acknowledge that I have had the opportunity to ask questions about this therapy and that my questions have been answered to my satisfaction.

By signing below, I consent to participate in the aforementioned therapy as described in this form.

Client Name: _____

Client Signature: _____

Date: _____