PINNACLE HOME PHYSIO & MASSAGE SERVICES

PHYSIOTHERAPY — HOME VISIT CONSENT & SERVICE AGREEMENT

Important: This form documents informed consent and home-visit arrangements. It is not a blanket waiver of professional negligence or a guarantee that no claim can be made. The provider remains responsible for competent practice, appropriate records and ongoing consent.

1. CLIENT AND VISIT DETAILS

Client full name: _____ Date of birth: _____

Home visit address: _____ Phone / email: _____

physiotherapist name: _____ Registration number: _____

Emergency contact / phone: _____ Primary care provider (optional): _____

2. HOME VISIT AND PROPERTY ACCESS

I invite the physiotherapist to enter my home at the address above only for the scheduled visit. This permission is limited to the visit and may be withdrawn. I will provide a reasonably clean, private, well-lit and safe treatment area with adequate space for equipment and movement. I will advise the provider about pets, smoking/vaping, infectious illness, unsafe flooring, stairs, other occupants or any known hazard. The provider may pause, modify or end the visit if the environment is unsafe, privacy cannot be maintained, I appear medically unwell, or safe care cannot be delivered. Any cancellation/visit fee is governed by the provider's disclosed policy and applicable law.

3. EXPRESS CONSENT TO PROFESSIONAL TOUCH / PHYSICAL CONTACT

I understand that assessment and treatment by the physiotherapist may require professional therapeutic touch and physical contact. Before touching me, the provider will explain the proposed contact, the body area involved, the reason for contact and the assessment or treatment technique. I give permission for appropriate therapeutic touch and physical contact only for the assessment and treatment that has been explained to me and that I agree to receive.

This permission may include, when clinically appropriate and specifically explained: placing hands on or moving an arm, leg, shoulder, neck, back or other relevant body area; palpating muscles or joints; guiding movement; assisting with positioning or transfers; applying manual techniques; and applying treatment equipment or electrodes to the agreed area. The provider must ask for and receive my consent before any new or changed intervention or contact that has not already been discussed. I may ask where and why I will be touched, request that contact stop or change, decline any body area or technique, or withdraw consent at any time.

My understanding and agreement: ■ I understand why therapeutic touch may be needed. ■ The areas and procedures will be explained before contact. ■ I may refuse or stop contact at any time.

4. PHYSIOTHERAPY ASSESSMENT AND TREATMENT CONSENT

The physiotherapist has explained the proposed assessment and treatment, purpose, expected benefits, material risks and side effects, reasonable alternatives (including no treatment), and possible consequences of declining treatment. I had an opportunity to ask questions. The plan may change and consent will be checked again when needed.

Possible interventions and risks (only when clinically appropriate and explained):

• **Physical assessment / exercise:** movement and functional testing, stretching, strengthening, balance and mobility exercises. Possible temporary soreness, fatigue, dizziness, symptom flare, loss of balance or fall.

• **Manual therapy / soft-tissue techniques:** temporary tenderness, soreness, bruising, swelling or symptom aggravation; additional risks may depend on health status and technique.

• **TENS / electrical stimulation:** possible skin irritation, discomfort or sensitivity; burns or injury can occur if unsuitable or incorrectly applied. I will disclose pacemakers/implanted electronic devices, pregnancy, seizure history, reduced sensation, skin conditions and other relevant conditions. Electrodes will be avoided over contraindicated areas.

• **Therapeutic laser / photobiomodulation:** possible temporary warmth, sensitivity or symptom flare; eye injury is a serious risk without appropriate eye protection. I will disclose photosensitivity, relevant medications, pregnancy, cancer history/active cancer, skin conditions and other concerns before treatment.

• **Other equipment:** the physiotherapist will explain its purpose, material risks, precautions and alternatives before use.

Individual responses vary and improvement is not guaranteed. I will immediately report pain, burning, dizziness, numbness, shortness of breath, unusual symptoms or discomfort. I may ask to stop or change any part of treatment at any time.

5. MODALITY-SPECIFIC CONSENT — INITIAL AFTER DISCUSSION

■ TENS / electrical stimulation discussed and consented to
■ Therapeutic laser discussed and consented to
■ Manual therapy discussed and consented to
■ Exercise / functional assessment discussed and consented to
■ Other: _____ ■ Declined: _____

6. HEALTH INFORMATION AND PRIVACY

I agree to provide accurate health information and update the provider if my health or symptoms change. Personal information and health records will be collected, used, stored and disclosed only as permitted or required by applicable BC privacy and health-profession laws, including care coordination, payment, insurance claims with my authorization, and legal or regulatory requirements. I may ask about the provider's privacy practices.

7. CLIENT RESPONSIBILITIES AND EMERGENCY PLAN

I will provide a safe treatment space, keep children and pets away from equipment, follow safety instructions and advise the provider if I feel unwell or uncomfortable. In an emergency, the provider may call 911 and/or my emergency contact and share minimum necessary information as permitted by law.
Emergency contact: _____ Phone: _____

8. ACKNOWLEDGEMENT AND SIGNATURE

By signing, I confirm this form was read or explained to me, I had the opportunity to ask questions, understand the proposed physical contact and treatment, and voluntarily consent to the assessment and treatment discussed. I understand this is not blanket permission for any touch or any body area. Consent is ongoing and may be withdrawn at any time. The provider will explain and obtain consent before new or materially changed contact or interventions.

Client / substitute decision-maker signature: _____ Date / time: _____

Printed name and relationship (if substitute): _____ Witness (if used): _____

physiotherapist signature: _____ Date / time: _____

CLINICIAN RECORD — COMPLETE AT EACH VISIT

Body area(s) and reason for contact explained: _____
Consent to physical contact obtained before contact: ■ Yes ■ No — details: _____
Risks, alternatives and questions discussed: _____
Interventions / techniques actually provided and client response: _____
Consent confirmed / modified / withdrawn and details: _____

Provider note: Keep a copy in the clinical record. A signed form does not replace a visit-specific consent discussion and documentation. Obtain and document consent before physical contact and before any new or changed intervention. Use equipment only when trained, authorized, insured and following manufacturer instructions and applicable professional standards.

PINNACLE HOME PHYSIO & MASSAGE SERVICES

SUBSTITUTE DECISION-MAKER (SDM) CONSENT ADDENDUM — PHYSIOTHERAPY

Use only when appropriate: A disability, diagnosis, communication difficulty or physical limitation does not by itself mean an adult is incapable of making a healthcare decision. The provider must assess the adult's ability to understand the information relevant to this particular decision, communicate in an appropriate way, and make reasonable efforts to obtain the adult's own decision. Follow applicable BC law and professional standards.

A. CLIENT DETAILS

Client full legal name: _____ Date of birth: _____
Home visit address: _____

B. CAPACITY / COMMUNICATION RECORD

The provider records the reason this addendum is being used for this specific healthcare decision (do not rely on diagnosis or disability alone):

_____
_____

Communication supports or accommodations offered (e.g., plain language, interpreter, communication aid, extra time, support person):

_____

Client's participation, wishes, assent, dissent or response observed and documented:

_____

■ Client is able to make this specific decision and gives their own consent — use the client signature section of the main form; SDM signature is not a substitute.
■ After appropriate communication support and assessment, provider has determined the adult is unable to make this specific healthcare decision at this time. Reason and supporting observations are documented above and in the clinical record.

C. SUBSTITUTE DECISION-MAKER INFORMATION AND AUTHORITY

SDM full legal name: _____ Phone: _____
Address / email: _____
Relationship to client: _____

Basis of authority (check and complete the applicable option):
■ Court-appointed guardian / committee of person — document / order reviewed: _____
■ Representative under a Representation Agreement — relevant authority and document reviewed: _____
■ Temporary Substitute Decision-Maker (TSDM) selected under applicable BC law — basis / priority category and eligibility confirmed: _____
■ Other lawful authority (specify and verify): _____

The provider has verified the SDM's identity and authority for this type of healthcare decision. Supporting document(s) reviewed / date / by whom:

_____

D. SDM DECLARATION AND SUBSTITUTE CONSENT

I confirm that I have authority to make this specific healthcare decision for the client. The physiotherapist has explained the proposed assessment and treatment, the body areas and physical contact involved, expected benefits, material risks, alternatives (including no treatment), and the right to ask questions. I have had an opportunity to ask questions. I have consulted the client to the greatest extent possible and will follow any instructions or wishes the client expressed while capable. If those wishes are not known, I will make the decision in accordance with applicable BC law, including the client's known beliefs and values or best interests as required.

I give substitute consent only for the following specific care discussed today (describe assessment, treatment, body areas / techniques and any modalities):

_____
_____

I understand this is not blanket permission for all treatment or all physical contact. The provider must explain and obtain consent for new or materially changed interventions as required. The client's current wishes, objections, distress or withdrawal of assent must be taken seriously; the provider will pause and reassess if the client objects or appears distressed. This consent may be withdrawn by an authorized decision-maker, subject to applicable law.

■ Consent given for the specific care described above ■ Consent not given ■ Further discussion / clarification required

SDM signature: _____ Date / time: _____
Printed name: _____ Relationship: _____

PROVIDER RECORD

physiotherapist name / signature: _____ Date / time: _____
Capacity assessment and rationale entered in clinical record: ■ Yes Authority verified and recorded: ■ Yes
Client involved / consulted to greatest extent possible: ■ Yes Details: _____

Important: This addendum does not authorize a person to sign merely because they are a spouse, parent, adult child or caregiver. The provider must confirm that the person has legal authority under the applicable BC process for this decision. For adults, follow the Health Care (Consent) and Care Facility (Admission) Act and applicable professional requirements. Obtain legal advice if authority or capacity is uncertain.