ACKNOWLEDGEMENT AND WAIVER

I,_____, give my consent for _____("Therapist"), to perform a vaginal and/or rectal examination for the purposes of evaluating my condition and providing therapeutic treatment. I also hereby acknowledge the following:

Patient Initials

1. I am 18 years or older; _____
2. I have been examined by a physician for this condition and assured that there is no underlying medical cause for this condition, beyond what a physical therapist can be reasonably expected to treat; _____
3. I am **NOT** pregnant at this time, nor do I have any reason to believe that I am pregnant; _____
4. This examination and treatment involves extremely sensitive touching, both ***internally*** and ***externally***; _____
5. I understand that I can terminate the procedure **at any time**; _____
6. I understand that I am responsible for informing the examiner if I experience any unusual symptoms or any type of discomfort during the procedure; _____
7. I understand that, given the sensitive nature of treatment, I have the option of having a second professional present during treatment.

   _____Yes, I would like to have an additional professional present.

   _____ No, I would not like an additional professional present.

_____
Patient Signature

_____
Printed Name

_____
Date