ADVANTAGE
Therapy Centers

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Pulmonary Rehabilitation Exercise Consent Form

I have been provided with information pertaining to my participation in Pulmonary Rehabilitation. I understand the purpose and objectives of this service and wish to participate. I understand that Pulmonary Therapy consists of regular evaluations to determine how I am progressing, possible tests, ongoing review of my symptoms, and compliance with my prescribed medications.

I realize that the exercise schedule will require 2-3 hours of time and several days per week. During the exercise sessions, I will be supervised by the Pulmonary Therapy staff that will be alert to any changes that might suggest modification of my exercise program. I have been instructed and understand that I am to report any change in symptoms promptly to the Pulmonary Therapy staff. I acknowledge that there is some risk in helping to make me more active and independent. These risks may include variations in blood pressure, heart rate, and/or medical conditions.

I authorize the Pulmonary Therapy staff to release any information obtained from my exercise sessions or evaluations to both my primary care physician and to others at my request.

I have read the foregoing and understand it. Any questions that have arisen or occurred to me have been answered to my satisfaction.

Patient Name _____ Witness Name _____

Patient Signature_____ Witness Signature _____

Date _____ Date _____