Advantage Therapy Centers

Vestibular Therapy Exercise Consent Form

I have been provided with information pertaining to my participation in Vestibular Therapy Rehabilitation. I understand the purpose and objectives of this service and wish to participate. I understand that Vestibular 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 1-2 hours of time and several days per week. During the exercise sessions, I will be supervised by the Vestibular Therapy Staff who are 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 Vestibular 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 Vestibular 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 _____