Heinen Physical Therapy, PC

CONSENT TO TREATMENT

I hereby consent to physical therapy evaluation and/or treatment by Brice and/or Lauren Heinen, PT, DPT or Reine Nola DPT who is licensed by and in good standing with the Oklahoma State Board of Medical Licensure and Supervision.

Physical therapy is a patient care service that is provided in order to manage a wide variety of conditions. Services are provided to individuals of all ages regardless of gender, color, ethnicity, creed, national origin, or disability.

The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis and intervention by use of rehabilitative procedures, mobilization, massage, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. The possible risks and benefits of treatment have been explained to me by the physical therapist including any complications or additional discomfort caused directly or indirectly by skilled physical therapy intervention.

I understand that physical therapy is not guaranteed to improve my condition and is not an appropriate treatment for everyone and in some unlikely cases may cause increased pain or discomfort. Response to physical therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol.

HIPPA NOTIFICATION

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- *Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.*
- *Obtain payment from third-party payers.*
- *Conduct normal healthcare operations such as quality assessments and physician certifications.*

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices at any time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.
I understand that I may request in writing for you to restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions. However, if you do agree, then you are bound to abide by such restrictions.
I understand that I may revoke this consent to use my protected health information in writing at any time, except to the extent that you have already taken action relying on this consent.

I have been given the opportunity to ask questions and all my questions have been answered to my satisfaction. By signing bellow, I confirm that I have read fully and understand the Consent to Treatment and Hippa Notification information above.

Signed:_____ Date:_____

Printed name:_____
Parent/Guardian if under 18:_____ Printed Name:_____