RENEW PHYSICAL THERAPY AND WELLNESS

HIPPA AUTHORIZATION AND CONSENT FORM

I understand that, under Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), 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 or indirectly.
- To disclose PHI about a patient to a third party
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you 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, but if you do agree then are bound to abide in such restrictions.

DUE TO FEDERAL PRIVACY RULES (HIPPA) we cannot speak to anyone other than yourself regarding your treatment without your consent. Please indicate the person(s) that you are authorizing us to release your personal protected health information to:

_____ PERSON _____ RELATIONSHIP TO PATIENT

_____ PERSON _____ RELATIONSHIP TO PATIENT

CONSENT TO TREAT

I hereby authorize Renew Physical Therapy and Wellness though its appropriate personnel to perform on me, or the patient listed above, appropriate assessment and treatment procedures relating to my diagnosis which may or may not include:

▪ **WOMENS HEALTH-** I understand that I am consenting for an exam which may include an internal evaluation of pelvic floor muscles. I consent to care for any musculoskeletal dysfunctions I may have, as well as an internal assessment of my musculature.
▪ **FUNCTIONAL DRY NEEDLING -** I understand that no guarantee or assurance has been made as to the results of this procedure and that it may not cure my condition. My therapist has also discussed the probability of success of this procedure, as well as the probability of serious side effects. Multiple treatments sessions may be required/needed, thus this consent will cover this treatment as well as consecutive treatments in the future.

I have read and fully understand this consent form and understand that I should not sign this form until all items, including my questions, have been explained and answered to my satisfaction. With my signature, I hereby consent to the performance of the procedure listed above.

You have the right to withdraw consent for this procedure at any time before it is performed.

_____ _____

Patient's (printed) (date)

_____

Patient's Signature