Date____/____/____

3 Dimensional Physical Therapy

Patient name _____

Acknowledgement of HIPAA

I acknowledge that I received, or was offered, information on HIPAA policy

I authorize 3 Dimensional Physical Therapy to discuss my Physical Therapy care with the following individuals (place line through empty lines)

_____
_____
_____

Initial _____

Consent to treatment:
I acknowledge that I am voluntarily seeking care from 3 Dimensional Physical Therapy. I authorize a licensed Physical Therapist to conduct an evaluation to determine a plan of care. I further authorize a licensed Physical Therapist or licensed Physical Therapist assistant to provide treatment based on an agreed upon plan of care. I acknowledge that there are some risks inherent with Physical Therapy. I understand that I have the right to question any care being provided and refuse recommended treatments. I acknowledge that the Physical Therapist or Physical Therapist Assistant is acting in my best interest, and cannot guarantee that desired results will be obtained.

Initial _____

Consent to medical information:
When appropriate for my care, I authorize 3 Dimensional Physical Therapy access to medical information from other providers, which includes, but is not limited to, imaging reports, operative reports, and physician notes.

Signature _____ Date _____/_____/_____
(Patient)

Signature _____ Date _____/_____/_____
(Parent/guardian if patient is a minor)

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