SW PHYSICAL THERAPY

11910 SW Greenburg Rd.
Tigard, OR 97223
503-597-1151

SW Physical Therapy HIPPA Consent Form

Consent for Release of Information: I authorize SW Physical Therapy to use and disclose my health information in order to make decisions about and plan for my care and treatment: refer to consult with , coordinate among and manage along with other health care providers; determine my eligibility for health plan or insurance coverage and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care: and perform various office, administrative , and business functions that support my doctor's efforts to provide, arrange and be reimbursed for my care.

I understand the consent that health information received or created in the course of the delivery of health care at SW Physical Therapy will be used in accordance with **SW Physical Therapy Notice of Privacy Practices**, which is posted in the lobby area; a copy of the NPP (notice of privacy practice) is available upon request for my review.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the matter described in the NPP, and I understand that SW Physical Therapy is not required by law to agree to such requests.

Signature: _____ **Date:** _____

If under 18 year of age Consent of parent: _____ **Date:** _____

Email Consent:

In compliance with the HIPAA omnibus final rule released January 2013 this consent form expresses that information contained in email messages may be privileged and confidential. There is some risk that any protected health information (PHI) that may be contained in such email may be disclosed to, or intercepted by, unauthorized third parties. Please be aware that email communication can be intercepted in transmission or misdirected. Your use of email to communicate protected health information to me indicates that you acknowledge and accept the possible risks associated with such communication. I Colbie Jorgensen of SW Physical Therapy will respond to your email query, but to do so via email, you must provide your consent, recognizing that email is not a secure form of communication. I will use the minimum necessary amount of protected health information, (PHI), to respond to your query. Please consider communicating any sensitive information by secure portal, telephone, fax, mail or in person at an appointment. If you do not wish to have your information sent by email even after signing this consent form, please fax (503-597-1150), mail, call me (503-597-1151) or make an appointment for an office visit so I can formally document your decision and discontinue email communication. If you wish to conduct discussions regarding your medical issues via email, please indicate your acceptance of this risk by signing below.

Email Address: _____ **Signature:** _____

Consent to Treatment

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. All procedures will be thoroughly explained to you before you are asked to perform them.

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. SW Physical Therapy does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury. It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment. I have read this consent form and understand the risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care. I authorize the release of my medical information to appropriate third parties.

Signature: _____ **Date:** _____