



RELEASE OF MEDICAL INFORMATION

I authorize the release of any medical or other information necessary to process medical claims and as necessary between Harrison Physical Therapy, LLC and other healthcare providers involved in my care.

SIGNATURE

DATE

CONSENT TO TREAT

I consent and agree to treatment as specified by Harrison Physical Therapy, LLC and as outlined in my personalized plan of care.

SIGNATURE

DATE

DIAGNOSIS CODES

A Physical Therapist diagnosis does not infer a Medical diagnosis. Harrison Physical Therapy, LLC uses the American Medical Associations ICD 10 codes for classification and communication purposes.

SIGNATURE

DATE

Dry Needling

Dry needling (DN) is a skilled technique performed by a physical therapist using a single-use, single-insertion, sterile filiform needle, which is used to penetrate the skin or underlying tissue to effect change in body conditions, pain, movement, impairment and disability. Like any treatment there are possible complications. While these complications are rare in occurrence, they are real and must be considered prior to giving your consent for dry needling treatment.

Risks of the procedure: The most serious risk associated with DN is accidental puncture of a lung (pneumothorax). If this were to occur, it may require a chest x-ray and no further treatment. The symptoms of shortness of breath may last for several days to weeks. A more severe lung puncture, while rare, may require hospitalization.

Other risks may include bruising, infection or nerve injury. It should be noted that bruising is a common occurrence and should not be a concern. The monofilament needles are very small and do not have a cutting edge; the likelihood of any significant tissue trauma from DN is unlikely.

There are other conditions that require consideration so please answer the following questions:



- Are you taking blood thinners? Yes / No
- Are you or is there a chance you could be pregnant? Yes / No
- Are you aware of any problems or have any concerns with your immune system?
Yes /No
- Do you have any known disease or infection that can be transmitted through bodily fluids? Yes / No

Patient's Consent:

I have read and fully understand this consent form and attest that no guarantees have been made on the success of this procedure related to my condition. I am aware that multiple treatment sessions may be required, thus this consent will cover this treatment as well as subsequent treatments by this facility. All of my questions, related to the procedure and possible risks, were answered to my satisfaction. My signature below represents my consent to the performance of dry needling and my consent to any measures necessary to correct complications, which may result. I am aware I can withdraw my consent at any time. I, authorize the performance of Dry Needling.

SIGNATURE

DATE

PRIVACY PRACTICES

Harrison Physical Therapy, LLC abides by the following:

PATIENT PRIVACY RIGHTS

Restrictions: You have the right to request restrictions on how your Protected Health Information (PHI) is used, however, we are not required to agree with your request. If we do agree, we must abide by your request.

Confidential: You have the right to request communications in a confidential manner such as providing alternate address or phone number

Access to Medical information: You have the right to inspect or request a copy of your medical information. A reasonable fee for copying and postage may be charged.

Amendments: If you disagree with any of your PHI, you have the right to request in writing an amendment be made. If a mutual agreement cannot be made, then the request is not required to be granted. In this case, your written statement of disagreement will



become a part of your record. Also, any part of your medical record that was created by other entities or providers may not be amended by this provider.

Accounting of Disclosures: You have the right to request an accounting of the disclosures made except for those that were made with your specific authorization or for treatment, payment or health care operations.

COMPLAINTS

At any time that you feel that your privacy rights have been violated, you may register a complaint in writing to dgmclaren@comcast.net. In no circumstance will you be penalized or receive retaliation for any complaint. If you are not satisfied with the response to your complaint, you may complain directly to the U.S. Secretary of Health and Human Services.

OUR DUTY TO PROTECT YOUR PRIVACY

We are required to comply with the federal health information privacy regulations by maintaining the privacy of your PHI. These rules require us to provide you with this document, Our Notice of Privacy Practices and to follow the terms listed. We reserve the right to update this notice. If we do update this notice at any time in the future, you will receive a revised notice when you next seek treatment from us.

SIGNATURE

DATE