

**WEST END**  
R e h a b  
**Physical Therapy**

**Consent for Purposes of Evaluation and Treatment**

I hereby authorize West End Rehab, through its appropriate personnel, to perform or have performed on me, or the above named patient, appropriate assessment and treatment procedures relating the condition(s) or specified by my referring physician.

**PATIENT SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_  
(or parent if patient is a minor)

**Consent for Purposes of Treatment, Payment and Healthcare Operations**

I consent to the use or disclosure of my protected health information by West End Rehab for the purpose of physical therapy evaluation and/or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of West End Rehab Physical Therapy. I understand that physical therapy assessment or treatment of me by West End Rehab Physical Therapy may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. West End Rehab is not required to agree to the restrictions that I may request. However, if West End Rehab agrees to a restriction that I request, the restriction is binding on West End Rehab and the specific physical therapist I am working with, employed by West End Rehab.

I have the right to revoke this consent, in writing, at any time, except to the extent that West End Rehab has taken action in reliance on this consent.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review West End Rehab’s Notice of Privacy Practices prior to signing this document. West End Rehab’s Notice of Privacy Practices has been offered to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of the West End Rehab. The Notice of Privacy Practices for West End Rehab is also provided at 4374 Dowlen Rd., Beaumont, TX. This Notice of Privacy Practices also describes my rights and West End Rehab’s duties with respect to my protected health information. West End Rehab reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment.

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**Signature of Patient** or Personal Representative

\_\_\_\_\_  
Name of Patient or Personal Representative

\_\_\_\_\_  
Date

Description of Personal Representative’s Authority