

CONSENT TO TREAT

Patient: _____
(Please print full name)

Date of Birth: _____

I hereby authorize TherapyWorks, Inc. to perform occupational, physical and/or speech therapy evaluation, administer therapeutic treatment as recommended in the initial evaluation and provide clinical services as deemed necessary by TherapyWorks, Inc. I understand that I will receive an explanation in understandable terms of the therapy recommended for the above named person, including possible side effects associated with treatment.

Insured/Guardian Signature: _____ **Date:** _____

RELEASE OF CONFIDENTIAL EVALUATION AND TREATMENT INFORMATION AND RECORDS TO AND FROM THERAPYWORKS, INC.

Notice to Patient: Your request for access to your protected health information is only applicable to the information maintained by the TherapyWorks, Inc. If you would like access to your protected health information maintained by any other Health Care Provider, a separate request must be submitted to that provider.

TherapyWorks, Inc. has my permission to release information about the above named patient and/or make contact with the following sources by whatever means necessary. (Source examples: your family, personal physician, health specialist, hospital, school or organization.)

| | |
|-------------------------------|----------------------------|
| Name: _____ Address: _____ | Phone: _____ Fax: _____ |
| Name: _____ Address: _____ | Phone: _____ Fax: _____ |
| Name: _____ Address: _____ | Phone: _____ Fax: _____ |
| Name: _____ Address: _____ | Phone: _____ Fax: _____ |

I, the undersigned, do hereby authorize these sources to release medical, surgical and/or psychological reports from the patient's records. This information will be used for occupational, physical and/or speech therapy evaluation and treatment. The information should be sent to:

TherapyWorks, Inc.
7608 East 91st Street, Suite 100
Tulsa, OK 74133

I hereby declare that I have read and fully understand all of the information above. I do hereby agree that all said information is true and correct. It is understood that I may revoke this treatment consent or release at any time by written request except to the extent that action has already been taken. I fully understand and agree to all the terms outlined above.

Insured/Guardian Signature: _____ **Date:** _____