**PART 2 LOCAL PATIENT PAPERWORK**

**Please fill out and send these pages.**

# PATIENT CONTACT INFORMATION

Name:

If Applicable, Name of Parent Or Guardian:

Address:

Phone Numbers (Please Indicate Which Is Best to Call):

Home:

Cell:

Work:

Email:

Best Day/Time to Call:

**We do not share your personal information. Please refer to document titled Patient Consent and Privacy (HIPPA) Policy.**

**HEALTH HISTORY**

Please briefly describe your medical history. There is additional space on the bottom of page 2.

Name ­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_ 2023

Age: \_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason For visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What do you think is the cause of your symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What do you think you need to get better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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When was your last physical? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Report any general symptoms you may have.

* Depression
* Dizziness
* Headache
* Loss of sleep
* Loss of weight

Current medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Hospitalizations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Surgeries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Injuries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Serious Illnesses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please describe any major illness in parents or siblings: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Is there anything else I should know? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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For women**:**

Please describe pregnancy history: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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When was your last Gynecologic visit including PAP smear? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pain Drawing**

Instructions: If you are using the online PDF filler, depending which Adobe products you have, you might not be able to fill this out online. If not, please print this page and fill out everywhere that you have symptoms. On your first visit you can elaborate on the type of sensation. While pain can vary day-to-day, the idea is to provide a general representation of how you have felt in the past week. Please also include any areas where you experience movement impairment even if not painful. Please scan as a PDF and send as an Email attachment, or FAX to 1-303-366-9445, or send via US Mail.

Please provide a numerical pain rating using a 1-10 Pain Scale for each region. It should represent the average pain, with an arrow pointing to the body region. Contact Jerry Hesch if you should have any questions.



From https://www .cfprc.com/pain-diagram.html (no spaces)

# INSTRUCTIONS FOR PATIENT NARRATIVE

Please complete and attach a brief narrative about your condition. You do not have to repeat information already mentioned on the Health History. You can be brief, however, please go into detail wherever you feel it is helpful.

The New Patient Packet and medical records maybe mailed to the home office address (Hesch Institute 25837 E Maple Pl Aurora, Colorado USA 80018, or attached as a *single* PDF or WORD file to an email and sent to info@heschinstitute.com .

Please include any and all pertinent information, such as:

1. Brief Overview of Medical History (please include all, even if seems to be unrelated)
2. Description of onset
3. Description of your symptoms, past and current.
4. What makes your symptoms worse, and what helps.
5. Treatments you have tried (including medications), and the outcome (from traditional AND non-traditional practitioners).
6. Tests you have undergone, including x-ray, MRI, CT, etc. Please attach test reports and bring original films or films on CD if available.
7. Please briefly list all health care practitioners you have seen for
	* + 1. consultation and treatment.
			2. What do you think to be the cause of your pain?
			3. What do you think you need to get better?
8. Please explain what you hope to accomplish.
9. Any other information you believe might be significant.

If you need additional space, please use a Word document or any blank sheet of paper.

# INFORMED CONSENT AND PERMISSION TO TREAT

I authorize permission to be treated by Dr. Jerry Hesch, DPT, MHS, PT, of the Hesch Institute, of Aurora and Denver, Colorado. All treatments, including manual therapy techniques, will comply with state and federal guidelines. Jerry Hesch, DPT, MHS, PT, is licensed in the state of Colorado to practice Physical Therapy, Colorado License # 00012320.

We comply with the APTA (American Physical Therapy Association), the Colorado State Physical Therapy Association, the American Academy of Orthopedic Manual Physical Therapy and the International Federation of Manual Physical Therapists, Code of Ethics, and the Physical Therapy Practice Act. The State of Colorado entitles a Physical Therapist Direct Access within specific guidelines. Direct Access allows a licensed Physical Therapist to evaluate and treat a patient without the need for a Physician’s referral or script. However, during the evaluation, should the Therapist discern that the patient requires medical referral or additional diagnostic tests, Dr. Hesch will recommend medical follow up.

I understand that I am an active participant in my therapy, and it is my responsibility to provide accurate and timely feedback to the Therapist regarding my response to any technique or exercise. It is my responsibility to keep my therapist updated on any change(s) in my healthcare status I also agree to immediately inform my therapist if I am experiencing during treatment any new sensation, any enhancement of existing abnormal sensation, any new symptoms, or any increase in existing symptoms. For example, I shall immediately inform the Therapist if I am experiencing increased pain, burning, tingling, numbness, dizziness, nausea, etc. As a Patient, I understand that I am in full control of my treatment, and I have the right to halt any technique or exercise at any time by telling my therapist to stop. The Therapist will comply with this request immediately.

I understand that very small gentle measured forces which are named spring tests/force-transmission tests will be applied to joints throughout my body. Treatment is similar, using gentle forces applied for a few minutes to coax the body’s cooperation, rather than impart abrupt forces as is common practice with joint-focused therapies. However, if any portion of the evaluation and treatment should be uncomfortable or cause new symptoms or increase in existing symptoms such as soreness, pain, numbness, tingling, temperature changes, etc., I am to report them immediately and the procedure will be stopped and interpreted and modified appropriately.

Again, this is a very gentle method, and it should not cause symptoms. Some injuries are highly sensitized and there is less than a 5% chance of symptoms being worse in response to treatment.

You are in control of your care, and this applies to any exercise or self-treatment in the clinic or at home. You can always decline treatment if you are uncomfortable with it or have concerns. I understand that on rare occasions soreness can result from hands-on treatment and from exercise, and it is extremely rare for patients to experience an increase in pain in response to the gentle treatment provided by Hesch Institute. I understand that Dr. Hesch and/or any other clinician is constantly vigilant in reading the response of my body to intervention, to provide safe and effective care.

As a patient I have the right to receive information regarding my care and can ask questions anytime.

Information can include but is not limited to:

* the planned examination/assessment
* the evaluation, diagnosis, and prognosis/plan
* the intervention/treatment to be provided
* the risks which may be associated with the intervention
* the expected benefits of the intervention
* the anticipated time frames
* the anticipated costs
* any reasonable alternatives to the recommended intervention

Signature of Patient Date

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Print Name of patient

**If this consent is signed by a Patient’s Representative, please complete the following:**

Signature of Patient’s Representative Date

Patient’s Representative Name (Print)

Describe Representative’s authority to act for patient.

\*From: <https://www>. ncbi.nlm.nih.gov/books/NBK500019/ (no spaces)

# HIPPA The Health Insurance Patient Portability and Accountability Act

I understand that there is a larger document named **Notice of Privacy Practices** which is available in the Patient Section and which I can download and print. It is also located on the bulletin board in the treatment room at Hesch Institute.

I understand there is a copy of the federally mandated **Notice of Privacy Practices (Notice)**, is available in the Patient Tab on the Hesch Institute website. It is available to download and print. It is also located in the Hesch Institute treatment room on the bulletin board. This page is an abbreviated form of that document. This HIPAA abbreviation describes the Practice’s obligation to ensure the privacy of my health information. The Notice also describes how the practice may use my health information for treatment, payment, and health care operations. I know that I have a right to review the Practice’s **Notice of Privacy Practices** and ask for clarification of the document. I understand Practice is required to maintain the privacy of my health information in accordance with the terms of the federally mandated HIPAA Privacy Notice.

I understand that I may, upon request, obtain a printed copy of the Practice’s HIPAA Privacy Notice I understand that my health care records will not be shared or discussed except as I specifically designate on the separate form entitled “Authorization to Disclose Health Information”. If I want my health information to be communicated to other Practitioners, or to any other party such as a relative, I shall designate any such Practice or individual on the Authorization form.

Signature of Patient Date

Name of patient (Print)

**If this consent is signed by a Patient’s Representative, please complete the following:**

Signature of Patient’s Representative Date

Patient’s Representative Name (Print)

Describe Representative’s authority to act for patient.

\*From: <https://www>. ncbi.nlm.nih.gov/books/NBK500019/ (no spaces)

# FINANCIAL POLICY

**For out-of-town clients**

Out-of-town clients are booked for an initial office visit which includes whole-body evaluation and whole-body treatment. On the following two visits you will be reevaluated and receive hands-on treatment as appropriate. You will be taught self-mobilization so that you will be independent of health care providers for mobility impairment. You will be taught an exercise program, ideal body mechanics and ergonomic principles. The goal is to make you as independent of healthcare providers as possible and significantly reduce your out-of-pocket expenses. and then follow-up care as needed, which typically takes at least three total visits of 1 to 2-hours each. This is a fee-based specialty service which is billed on Day 1 is $350.00, Day 2 is $300.00 and day 3 is $300.00. On occasion, especially for simple presentations, only two visits are needed, and, in those cases, there is no charge for day 3.

Although rare, for complex presentations if additional time or additional number of visits are utilized, they are billed at $37.50 per 15-minute unit. Although this is specialty care, our fees for services are significantly lower than traditional physical therapy clinics and specialty PT services. Due to our small size, our commitment to one-on-one care without the use of allied care providers (assistants, technicians, etc.) our time investment in your care is much greater. Dr. Hesch’s education can be reviewed online on the home page search function on upper right corner typing: Jerry’s Curriculum Vitae.

* The fees also apply to history taking, review of records, letters to providers, telephone, and email communication.
* Payment for all services is due at the time of service. We accept cash, US checks\*, and credit cards. We can get credit card information by telephone M-F, 8am-5pm PST, at (303) 366-9445 (\*if paying by check please make checks out to Hesch Institute). We also take Flexible Spending Account, Health Spending Account etc. cards.
* Within 5 business days of your final visit you will receive a receipt for the amount paid.
	+ You will also receive a coded receipt for each visit. However, due to complexity it may be less than the actual amount paid. Hesch Institute charges a straight fee for each visit and the CPT codes used will reflect care provided per allowed coding, but as Hesch Method is a unique form of care in which we do not provide cookie-cutter care, we charge a flat fee, and the care is not based on units of time, and it is not based on units of service. The units listed on the receipt reflect actual units that are reflected in the note and are defensible, although it may be less than the fee amount. Please consult your insurance provider for any questions. The Hesch Institute is not in network for any insurance provider as we are a cash-based practice. Some insurance companies may reimburse a portion of the submitted claim while others do not pay anything as we are out of network. Nonetheless, the amount paid should go against your annual deductible. Please reread this section and contact Hesch Institute for any questions.
* Hesch Institute reserves the right to refuse service to anyone if the clinician determines that care is not appropriate, or that a therapeutic relationship is not present. If after reviewing your paperwork, should Dr. Hesch determine that you may benefit from additional imaging or specialty consultation (example, rheumatology, pain management, etc.) he will make that recommendation.

Signed

Date:

# CANCELLATION AND NO-SHOW POLICY

Patient care at Hesch Institute is individual, hands-on treatment and education by Jerry Hesch, DPT, MHS, PT. Dr. Hesch sees one patient at a time. There will be no Physical Therapy Assistants or other staff participating in your care. You will receive one-on- one care for the duration of your visits.

Patients who don’t show or cancel with less than 24 hours’ notice, will be asked to pay a cancellation fee prior to their next appointment. The fee is $50.00.

By signing below, I agree to compensate Hesch Institute for any appointment to which I do not show or cancel with less than 24 hours’ notice.

Signed

Date:

**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

Hesch Institute 25837 E Maple Pl, Aurora, Colorado 80018

Fax - 303-366-9998 Phone-303-366-9445.

**This form is optional. It’s only to be completed if you want Hesch Institute to share information with someone you choose.**

Dr. Hesch can provide you with a letter summary of your presentation and treatment upon request.

**Print Name**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_authorize the use or disclosure of the above-named individual’s health information as described below:

Dr. Jerry Hesch, DPT, MHS, PT, and Hesch Institute, are authorized to make the disclosure of the following information: Case records, including (check all that apply):

 History and Physical

 Treatment Record

 Discharge summary or letter

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other

These records are for the dates of care from: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This information may be disclosed to and used by the following individual(s) or organization(s). Please list any practitioner(s) or other party from whom you wish to receive records. Please provide contact information.

NAME, TITLE ADDRESS PHONE/FAX

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Dr. Jerry Hesch, DPT, MHS, PT or Karin French-Hesch of the Hesch Institute. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If no expiration date, event, or condition is specified, this authorization will expire in 5 years.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed. If I have questions about the disclosure of my information, I can contact Jerry Hesch, DPT, MHS, PT or Karin French-Hesch at Hesch Institute.

Signature Of Patient Date

Print Name

**If Signed by Legal Representative, Authority to Act For Patient:**

Signature Of Legal Representative Date

Signature Of Witness Date