



Consent / Authorization

Consent for Treatment

I understand that I have been referred by my physician for physical therapy services. I may be subject to various therapeutic modalities and procedures involving moist heat, ice packs, ultrasound, electric stimulation, paraffin wax, whirlpool, therapeutic exercise, massage, traction, joint mobilization, and other organized procedures utilized by licensed physical therapists. I hereby authorize treatments to be rendered on me. (If patient is under the age of 18, a parent or guardian must sign this consent form.)

Patient / Parent or Guardian

Date

Assignment of Benefits / Release of Information

I hereby assign payment for services rendered to me (or my dependent). I authorize to disclose all or any part of my (or my dependent's) record to my physician and any other person or corporation which may be liable for all or any part of the charges including but not limited to insurance companies, Worker's Compensation carriers, or employers.

Patient / Parent or Guardian

Date

HIPPA Rights and Responsibilities

I acknowledge that I have seen the "Notice of Privacy Practices" and understand that I may ask questions about this policy at any time.

Patient / Parent or Guardian

Date