ORTHOPEDIC EDGE physical therapy

CONSENT TO TREATMENT FORM

Patient's Name: _____

Patient's DOB: _____

1. **Consent:** I request and authorize physical therapy treatment as may be deemed necessary and appropriate by the physical therapist. This care may include all physical therapy modalities, exercises, and manual therapy.
2. **Release of Information:** I authorize Orthopedic Edge PT to release pertinent information and/or copies of medical records for treatment, payment or health care purposes. I understand that such information may include HIV, AIDS related complex, AIDS, Hepatitis, substance abuse, psychiatric/psychological services records and social work records if any.
3. **Valuables**: I release Orthopedic Edge PT from the responsibility for all personal articles which I have with me during the time that I am a patient at OEPT. I understand that OEPT is not responsible for clothing, glasses, jewelry, money or other personal articles of value kept in my possession while I am a patient at OEPT.
4. **Payment**: I assign and authorize payment from my insurance company directly to Orthopedic Edge PT for any and all services rendered. I agree to pay, at the time of DC, all changes not covered by my insurance company. I understand that it is my responsibility to pay OEPT all charges for PT services rendered irrespective of any disputes or disagreements between my self and my insurance company.
5. **No Guarantees**: I am aware that the practices of physical therapy are not an exact science and I acknowledge that no guarantees or promises have been made to me as to the results of PT which I have hereby authorized.

I have read this form and it has been read to me and I am satisfied that I understand its contents. I further understand that this consent will be deemed continuing and I am free to withdraw my consent at any time.

_____ _____

Date Signature of Patient/Parent

_____ _____

Signature of Witness Relationship