ORTHOPEDIC EDGE PHYSICAL THERAPY

51064 Filomena Drive | Shelby Twp, MI | 48315 | (586) 566-5116

CONSENT TO TREATMENT FORM

Patient Name:_____

Patient 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 to the rendering insurance carrier, referring doctor, or third party administrator (lawyer, medical records department, etc) that is accompanied with a signed authorization form from the patient.

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 Orthopedic Edge (OE). I understand OE is not responsible for clothing, glasses, jewelry, money, or other personal articles of value kept in my possession while I am a patient at OE.

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 discharge, all charges 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 myself 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 result of PT which I hereby authorize.

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

_____

Signature of Patient/Parent Date