WEST TOWN
PHYSICAL THERAPY

Consent to Treat Form

I hereby give authorization for the performance of such rehabilitation procedures as permitted by West Town Physical Therapy under the appropriate scope of practice that are, in the judgment of my therapist, deemed necessary.

I agree that West Town PT may provide information from my medical record to persons involved in my medical care.

I authorize the release of medical information necessary to obtain payment of any benefits available to me to West Town PT for services rendered.

I agree that West Town PT may obtain information from others who have provided medical care to me and/or are responsible for the payment of all or part of my bills when this information is needed in order to treat, bill, and/or receive payment.

I agree that although West Town PT may provide me with insurance verification of benefits, it is ultimately my responsibility to know my insurance coverage and pay the charges that are not covered by my health insurance plan.

I authorize that direct payment of any benefits available to me be released to West Town PT for services rendered.

I agree to pay West Town PT charges for services rendered to me during my course of treatment.

_____

Printed Name

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Signature Date