SPECTRUM PHYSICAL THERAPY

Consent for Outpatient Physical Therapy Treatment

Authorization

I hereby authorize licensed Physical Therapists and/or Physical Therapist Assistants to provide medical care and administer such treatment as deemed necessary or advisable and prescribed to the named patient or myself each time presenting to the facility at 100 Hospital Road, ste. 112. To the extent possible, I have been informed of the risks and complications as well as the potential benefits that may occur and alternatives that may be available. I acknowledge that no guarantees or assurances have been made to me concerning the results intended from my treatment.

Medicare Patients

I authorize any holder of medical information about me to release the Social Security Administration or its intermediaries or carriers any information needed for this or any related claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment below. I also understand that it is my responsibility to obtain a new prescription from my doctor every 30 days from the date of the original prescription.

Please Initial X__________

Guarantee of Account

For and in consideration of services rendered to ____________________________, by ***Spectrum*** Physical Therapy, I hereby agree to pay the full bill for all charges that are not covered or that are not paid to Spectrum Physical Therapy by insurance or Worker's Compensation, or any balance due that is not covered by insurance or excluded by co-insurance clause. I understand that any payments directed to me by my insurance company, for the intent of payment to Spectrum PT, must be forwarded directly to Spectrum PT by me.

Therapists

Please be advised that we have multiple therapists on staff. We cannot guarantee which therapist you will see on each visit. We will try our best to accommodate you if you should have a preference. At your therapist's discretion, if you are more then 15 minutes late for your scheduled appointment time, your therapy session will be shortened or rescheduled.

Please Initial X__________

I understand that I have a $_______ co-payment for each office visit, including the Evaluation appointment. These payments may be made on a daily or weekly basis. *Please Initial X_______*

Release of Information

I permit ***Spectrum*** Physical Therapy to disclose all or part of the above patient's medical records to any person, corporation, or agency when required for collection of benefits or payment of charges.

Assignment of Benefits

I assign to ***Spectrum*** Physical Therapy all benefits from any corporation/Insurance Company, agency and/or person for the services rendered. I authorize payment of these benefits directly to ***Spectrum*** Physical Therapy.

I confirm that I have read and fully understand the above statements.

Date:______________ **Patient Signature: X_____________________________**

Relative or Guardian (If pt is under age 18) **Print Name:____________________________**