Consent to Treat

I authorize the treatment of my condition through physical therapy to CLINTON PHYSICAL THERAPY.

Authorization for Release of Medical Records

I authorize the release of any medical records or other information necessary to process my insurance claims or to aid in my treatment plan.

Patient Responsibility

I acknowledge responsibiliy for the payment of services to CLINTON PHYSICAL THERAPY.

Authorization for Assignment of Insurance Benefits

I authorize payment of medical benefits to CLINTON PHYSICAL

Please initial below if your Insurance does not pay 100%

________ I agree to pay my co-pays and/or co-insurance in full upon each

Acknowledgement Form

I have received the Notice of Privacy Practices and have been provided the opportunity of review it.

____ ______________

Patient or Patient's Legal Guardian's Signature ***Date***