PATIENT CONSENT FORM

I hereby authorize Professional Therapy Associates, Inc. and any of their representatives to provide physical therapy to myself or to any minor (under age 18) that I represent. I understand that by signing this form myself, or the minor I represent, are consenting to treatment.

AUTHORIZATION TO OBTAIN INFORMATION

I understand that I am authorizing Professional Therapy Associates, Inc. to obtain any test results or patient information in order to assist with the provision of care.

AUTHORIZATION FOR RELEASE OF INFORMATION

I understand that I am authorizing Professional Therapy Associates, Inc. to release any and all pertinent information regarding my physical therapy to my doctor, insurance co., attorney, etc.

ASSIGNMENT BY RESPONSIBLE PARTY/FILE SIGNATURE

In consideration of any medical care provided to the patient named below, I assign to Professional Therapy Associates, Inc. all my rights to any and all medical insurance benefits to which I am or may be entitled by any health plan. This assignment will remain in effect until revoked by me in writing. A copy of this assignment is to be considered as valid as an original.

PAYMENT POLICY

I understand that I am responsible for any balance after my insurance considers their liability(regardless of whether I have hired an attorney for an accident claim). I understand that it is my responsibility to check if physical therapy is a covered item in my medical insurance plan. I also understand that I am responsible for any referrals and knowing any limitations (number of visits) that my insurance plan may have, including medical supplies. Medicare requires you to see a physician every 30 days to remain eligible for coverage for therapy. I also understand that most insurance companies may not pay for some durable medical equipment. I UNDERSTAND THAT IT IS ULTIMATELY MY RESPONSIBILITY TO PAY FOR ANY AND ALL SERVICES PROVIDED TO ME BY PROFESSIONAL THERAPY ASSOCIATES, INC.

_____ _____

Patient/Guardian Signature Date