McKENZIE
CROSSING
ORTHOPEDIC PHYSICAL THERAPY

CONSENT FOR CARE AND TREATMENT

I, ____________________, do hereby agree and give my consent to McKenzie Crossing Orthopedic Physical Therapy to furnish medical care and treatment considered necessary and proper in treating my physician diagnosed physical condition.

I, hereby assign all medical benefits for treatment provided in the clinic to which I am entitled, including Medicaid, Medicare, private insurance, worker's compensation insurance, motor vehicle insurance and other third party payers to McKenzie Crossing Orthopedic Physical Therapy. A photocopy of this assignment is to be considered as valid as the original. I, hereby authorize the clinic to release all information necessary including medical records, to secure payment.

The clinic will bill your insurance carrier for you, providing we have complete insurance information at the time of the visits. Copays/percentages and deductibles are determined by your insurance company. Questions regarding these should be directed to them.

Any patient who no shows an appointment or cancels without a 4-hour notice on two occasions will be discharged and all future appointments will be cancelled.

I declare that I have read and understand the above information and am responsible for the payment of my account in a timely manner.

Signature: ____________________________________ Date:__________________

HEIGHT:

WEIGHT: