AUTHORIZATION FOR TREATMENT AND CONSENT FOR CARE

I hereby voluntarily consent to Physical Therapy provided by *Professional Physical Therapy Center*, its physical therapist and assistants as explained to me by the Physical Therapist and whomever he/she may designate as his/her assistant. I am aware that the practice of medicine is not an exact science and that any procedure has an inherent risk. I acknowledge that no guarantees can be made to me as a result of any treatment or examination in the office.

I understand and agree that I am personally responsible for payment of all services rendered. Health and accident policies are an arrangement between an Insurance carrier and myself; however, *Professional Physical Therapy Center* may accept certain insurance assignments of benefits. The acceptance of Insurance assignment is individually determined and prior authorization is required. I understand that upon termination of care, any outstanding charges for professional services rendered will be immediately due and payable.

Patient Signature_____ Date_____

Relationship, if Guardian_____