



Consent for Treatment

Patient Name: _____

Consent for Evaluation and Treatment:

I hereby give permission for treatment and evaluation as well as therapy that was ordered by my physician.

Authorization to pay for Services:

I hereby authorize payment directly to my insurance and otherwise payable to the undersigned, but not to exceed therapy's regular charge for this service upon completion of a physical therapy session.

Agreement of Insurance Coverage:

I understand that if Mulligan Physical Therapy does not accept my insurance I will be responsible for payments made directly to Mulligan Physical Therapy in the form of out of network coverage or co-pay expenses. If my insurance denies payment to Mulligan Physical Therapy, I understand that I will be responsible for payments or charges not covered by my insurance.

HIPPA Agreement/ Authorization to release Information:

I () agree, () disagree to authorize Mulligan Physical Therapy to disclose confidential health information to include (name, address, SS#, employer, date of birth, relative's names, phone/fax #, e-mail address, Medical record #, Account #) or any necessary information related to my financial records or medical records to a family member or close personal friend, who is involved in my care or by those with the appropriate need to do so, such as insurance, physician or other healthcare professionals.

Signature

Patient/Guarantor: _____ Date: _____

Parent/Guardian: _____ Date: _____
(if patient is under the age of 18)

Staff/Title: _____ Date: _____