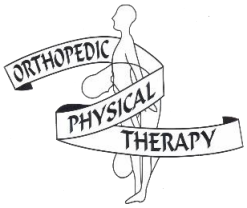

ORTHOPEDIC PHYSICAL THERAPY

AUTHORIZATION TO TREAT:

I hereby authorize Sports Medicine Inc., d/b/a Orthopedic Physical Therapy, to evaluate and treat me/my minor child with those modalities and procedures recommended by my/his/her physician and physical therapist.

APPOINTMENT REMINDERS: Please Circle One

Email-Preferred Choice Email Address _____
Print Clearly

Text Messages Cell #_____ Cell Phone Carrier_____
*Standard Text Messaging Rates May Apply

Phone Calls Phone #_____

OBLIGATION TO OBTAIN REFERRAL:

I understand that it is my responsibility to obtain all necessary orders or referrals, and that failure to do so will result in financial obligation.

OBLIGATION TO NOTIFY US OF PRIOR TREATMENT:

I understand that I am responsible for any services denied if I have failed to notify Sports Medicine Inc. d/b/a Orthopedic Physical Therapy of treatment rendered elsewhere.

I have had other physical therapy services ***in 2018 and 2019*** **NO**
YES - Where: _____

AUTHORIZATION TO PAY BENEFITS:

I hereby authorize my insurance carrier to make payment directly to Sports Medicine Inc. d/b/a Orthopedic Physical Therapy for all services rendered.

OBLIGATION TO PAY:

Any charges not covered by my insurance, any deductibles, coinsurances, or copayments required by my insurance plan, **I understand I am responsible for payment**

PRIVACY POLICY:

I was provided a copy of Sports Medicine Inc. d/b/a Orthopedic Physical Therapy's Notice of Privacy Practices

I HAVE READ AND AGREE TO THE ABOVE:

_____

print patient name

_____

signature of patient (Must be 18 or older to consent to treatment) **date**