You must be 18 years or older in order to sign the following authorizations

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. I also understand that my treatment may include the use of equipment and facilities at The Body Shoppe Health and Fitness Center and consent to allow continued treatment in that environment.

APPOINTMENT REMINDERS – PLEASE *CIRCLE* YOUR PREFERENCE:

Phone Calls　　Phone # ______________________________

Or　Text Messages　　Cell # _________________________ Carrier (eg. Verizon) ____________________
*Standard Text Messaging Rates May Apply

Or　Email　　Email Address ____

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 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:

I understand that I am financially responsible for any charges not covered by my insurance, as well as any deductible, coinsurance or copayment required by my insurance plan.

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 (or parent if a minor child)　　　　**date**