PROFESSIONAL REHAB KARE, P.C.
THOMAS F. PRICE, LPT

PATIENT_____INSURANCE COMPANY_____

CONSENT TO TREATMENT AND RELEASE OF INFORMATION

I UNDERSTAND THAT I HAVE BEEN REFERRED FOR REHABILITATIVE TREATMENT AND CARE TO PROFESSIONAL REHAB KARE. PROFESSIONAL REHAB KARE HAS DESCRIBED FOR ME MY INDIVIDUAL TREATMENT PLAN. I UNDERSTAND THAT I HAVE THE RIGHT TO ASK AND HAVE ANY QUESTIONS ANSWERED PRIOR TO RECEIVING ANY TREATMENT INCLUDING ANY RISKS OR ALTERNATIVES TO THE TREATMENT PLAN THAT HAS BEEN PRESCRIBED FOR ME. BY SIGNING THIS AGREEMENT, I CONSENT TO HAVE PROFESSIONAL REHAB KARE PROVIDE TREATMENT AND CARE AS PRESCRIBED BY MY PHYSICIAN AND/OR RECOMMENDED BY MY PHYSICAL THERAPIST.

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO MY PHYSICIAN(S) OR TO MY INSURANCE CARRIER IN ORDER TO PROCESS ANY CLAIMS.

SIGNATURE: _____

DATE: _____