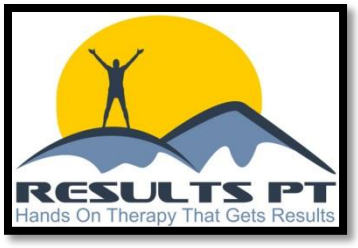

REQUEST AND CONSENT FOR TREATMENT
AGREEMENT TO CONDITIONS OF ADMISSION

MY REQUEST AND CONSENT FOR TREATMENT:

This is my request and consent for physical therapy services, and permit the attending physical therapist to contact and consult with the referring physician regarding my care and treatment. I consent to any evaluation procedures required to formalize a physical therapy treatment plan. I authorize RESULTS PT to obtain any medical reports, x-rays, imaging studies to be reviewed by the physical therapist in order to make treatment decisions regarding my care. I also authorize those physicians or medical facilities to release these reports and studies to RESULTS PT for confidential review which will become part of my medical record.

RELEASE OF INFORMATION FOR INSURANCE:

I agree to allow RESULTS PT and the people who work for them to release information from the patient's medical record to any insurance carrier that requires this information to reimburse me for the physical therapy services. I understand that my insurance agreement is between me and my insurance company. I understand that RESULTS PT does NOT bill for services rendered. Insurance plans vary widely in coverage for medical services. It is my responsibility to check my insurance coverage and not assume that physical therapy services are a covered benefit under my plan. Furthermore, I understand that RESULTS PT will provide the services rendered with billing codes on their invoice for me to submit my insurance claims. The cost to provide additional information requested from insurance companies is not included in RESULTS PT charge for services and may require the patient to cover those costs.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received or reviewed the Notice of Privacy Practices.

I have read this agreement (or had it read to me) and I understand the above statements. I agree that by signing this form, I am bound by what it says, whether I am the patient or that person who is authorized to act on the patient's behalf.

PRINT NAME _____

SIGNATURE_____ **DATE**_____

WITNESS _____ **DATE** _____

(IF PATIENT IS A MINOR)