Endurance
PHYSICAL THERAPY

Consent for Care and Treatment

I, _____, do hereby agree and give my consent to Endurance Physical Therapy to furnish medical care and treatment considered necessary and proper in treating my physician diagnosed condition.

I, hereby assign all medical benefits for treatment provided in the clinic to which I am entitled, including Medicaid, Medicare, private insurance, worker's compensation insurance, motor vehicle insurance, and other third party payers to Endurance Physical Therapy. A photocopy/scan of this assignment is to be considered as valid as the original. I, hereby authorize the clinic to release all information necessary including medical records, to secure payment.

In the event an account must be referred to a third party for collection, the customer agrees agrees to pay all reasonable collection and/or attorney fees, as well as court costs incurred to effect collection.

The clinic will bill your insurance carrier for you, providing we have complete insurance information at the time of the visits. Co pays/percentages and deductibles are determined by your insurance company. Questions regarding these should be directed to them.

I authorize Endurance Physical Therapy to discuss ANY information regarding my care/account with the below-mentioned persons. Only list names of persons you are authorizing to discuss ANY information with.

Name: _____ Relationship: _____

Phone: _____

Name: _____ Relationship: _____

Phone: _____

I declare that I have read and understood the above information and am responsible for the payment of my account in a timely manner.

_____ _____

Signature of Patient or Legal Representative Date