Restor Physical Therapy
P.O. Box 8125
Fountain Valley, CA 92728-8125
Office: 714-754-7268
Fax: 714-434-7042

Consent to Treatment and Conditions of Treatment

Consent to Treatment: I _____

Consent to the procedures, which may performed during my treatment and care at RESTOR PHYSICAL THERAPY, including emergency treatment or services. These may include but are limited to therapeutic test, treatments and procedures, manipulation, stretching, or exercise treatment or procedures as directed under the general instructions of the Physical Therapist or Aide. I am aware that the practice of Physical Therapy is not an exact science and that no guarantees have been made to me. I authorize my Physical Therapist to take photographs relating to my physical condition as are deemed necessary.

Release of Information: RESTOR PHYSICAL THERAPY is authorized to release any information necessary, including copies of my Therapy and medical records to process payment claims for health care services, which have been provided. Such records may include information of a psychological or psychiatric nature, pertaining to my mental condition or treatment for conditions relating to the use of alcohol or drugs. In addition, I authorize my insurance carrier, employer or person otherwise responsible for payment to provide to RESTOR PHYSICAL THERAPY information necessary to determine benefits or process a claim. This release will be valid for the period of time to process the claim or until consent is revoked by the patient.

Financial Agreement/Assignment of Benefits: I assign any and all insurance benefits payable to me to **RESTOR PHYSICAL THERAPY**. I understand that I am responsible for payment of services rendered by **RESTOR PHYSICAL THERAPY** including excluded services from my insurance either because of the plans deemed such services not medically necessary, or for any other reason including pre-certification requirements, second opinions or preexisting conditions. Should the account be referred to any attorney or collection agency for collection, I understand that I will be responsible for attorney and/or collection expenses. I, the undersigned, state that the information that I have provided **RESTOR PHYSICAL THERAPY** is correct to the best of my knowledge. I acknowledge by my signature that I have read and received a copy of this statement.

_____ Date _____
Signature of Patient or Representative

_____ Date: _____
RESTOR Physical Therapy Representative