Witte PHYSICAL THERAPY

CONSENT TO TREATMENT

1. CONSENT TO TREATMENT
   I, knowing that I have a condition requiring diagnosis, treatment, or related care do hereby consent to such care, physical therapy examination, procedures, interventions, and/or treatment by a physical therapist, their assistants or aides, as may be necessary in their professional judgment. I further acknowledge that no guarantees have been made to me as to the results of such care, physical therapy examinations, procedures, and/or interventions. I also authorize release of such information to the third party payor(s).

2. ASSIGNMENTS OF BENEFITS
   I hereby assign to Witte Physical Therapy and to all therapists providing treatment(s) all right, title, and interest, in and to the benefits payable affording clinic and therapist's coverage. I direct that such benefits be paid directly to said clinic and therapists.

3. INSURANCE PRE-CERTIFICATION INFORMATION
   Many insurance companies have pre-certification requirements for physical therapy. If you are not sure whether your insurance company had pre-certification requirements, please check before evaluation and/or treatment so that you will not be denied insurance benefits for this/these visit(s).

4. AUTHORIZATION FOR RELEASE OF INFORMATION
   I hereby authorize Witte Physical Therapy to furnish records from any treatments, photocopies of such records and/or information, and excerpts from such records to the attending physician, his/her associates, and/or consultants, and third party payor (whether an insurance company, government agency, or self insured employer) and/or any transferee health care facility and/or agency for the purposes of obtaining payment for services rendered while under clinic care, performing utilization review, and/or post care and treatment. If this is a work related injury I authorize Witte Physical Therapy to provide my employer with any and all needed information related to my condition. Finally, if further care from another therapist, physician, or specialist were needed I authorize the release of my records to such a party.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING, AND IS THE PATIENT, OR IS DULY AUTHORIZED BY OR IN BEHALF OF THE PATIENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

Responsible Patient/Party/Insured: _____

Responsible Patient/Party/Insured: _____

Witness: _____

Date and Time: _____