

CONSENT FOR TREATMENT

I, the undersigned, hereby agree and give my consent to SPORTS REHAB AND PROFESSIONAL THERAPY ASSOCIATES (a.k.a. SPORTS REHAB) to administer such treatment and care as is prescribed and considered therapeutically necessary based on findings during treatment.

I also authorize SPORTS REHAB to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for the services rendered. The information provided is accurate to the best of my knowledge.

Patient Name *(please print)*

Signature

Relation *(self, parent, guardian, etc.)*

Date