

RESTOR Physical Therapy @ Shoreline
1235 Pear Ave. Ste. 101
Mountain View, Ca 94043
650.965.8434
Fax 650.965.8545

Consent to Treatment and Conditions of Treatment

Consent to Treatment: I, _____
consent to the procedures, which may be performed during my treatment and care at **RESTOR Physical Therapy**, including emergency treatment or services. These may include but are not limited to therapeutic test, treatments or 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(s) to take photographs relating to my physical condition as are deemed necessary.

Release of Information: RESTOR Physical Therapy is authorized to release my 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** 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 was given a copy of this statement.

Signature of Patient or Representative

Date

RESTOR Physical Therapy Representative

Date