REVOLUTION PHYSICAL THERAPY NYC

I, the undersigned, hereby give my consent for Revolution Physical Therapy NYC to furnish medical care and treatment considered necessary to diagnose and treat _____. I recognize that results may vary and that no assurance or guaranty has been made by anyone regarding the outcome of my treatment.

I acknowledge that I am legally responsible for all charges in connection with the medical care and treatment provided by representatives of Revolution Physical Therapy NYC. I assign and authorize payments directly to Revolution Physical Therapy NYC.

Important information about your privacy rights: Revolution Physical Therapy NYC will use and disclose your personal health information only for treatment, payment, and to conduct healthcare operations related to your care. You may be provided with a detailed Notice of Privacy Practices to help you better understand our policies regarding health information.

If you have any questions about your health, your treatment, or any aspect of your physical therapy, please feel free to discuss with your physical therapist.

I have read and understand this document. Any questions that I had were answered to my satisfaction.

_____ _____

Patient Name (print) Date

_____ _____

Signature of Patient of Authorized Representative Date

_____

Physical Therapist