CONSENT FOR TREATMENT

Patient's Name:

I Hereby authorize and consent to examination and treatment as deemed necessary by the providers of Norum Physical Therapy, LLC for myself or my minor child named herein on this form.

I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments. I fully understand that it is impossible to make any guarantees regarding the outcome of any medical treatment.

I authorize release of information to my insurance carrier should it be necessary. The undersigned agrees to pay any costs incurred by Norum Physical Therapy, LLC in the event of account delinquency, all amounts due, including but not limited to reasonable attorney fees.

Patient's or Guardian Signature:____ Date:____________

MEDICARE LIFETIME SIGNATURE ON FILE:

"I request that my payments of authorized Medicare benefits be made on my behalf to Norum Physical Therapy, LLC for any services furnished me by the physical therapists of Norum Physical Therapy, LLC.

I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services"

Patient's or Guardian Signature:____Date:____________

PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS/INFORMATION RELEASE:

"I, the undersigned authorize payment of medical benefits directly to Norum Physical Therapy, LLC for any services furnished to me by the provider. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent, information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits. "

Patient's or Guardian Signature: ____ Date:____________

I, ____hereby acknowledge that I have received a copy of the HIPAA/Notice of Privacy Practices and understand it's content.

Patient or Guardian Signature:____

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