**Authorization for Treatment**

1. I hereby request and consent to treatment of physical therapy at *Impact Health and* *Performance, (“Provider”),* as outlined in the treatment Plan of Care developed in collaboration with my attending physician. I understand the provider will place hands on me to provide therapy services. I consent to Provider’s hands on me during the rendition of therapy services and agree to cooperate with all reasonable requests which Provider, in the exercise of reasonable clinical judgment, believes necessary to achieve the objectives of the treatment Plan of Care.
2. I understand I can discuss with Provider the nature and purpose of treatment Plan of Care and procedures which Provider will use in following the treatment Plan of Care as well as the risks which can result from a physical therapy regimen.
3. During treatment, I wish to rely on the Provider’s judgment as to what is in my best interest understanding the Provider’s judgment will be based upon the facts of my condition then known by the Provider.
4. I have read the above consent. I have also had the opportunity to ask questions about its content and by signing below I agree to the Treatment Plan of Care for my present condition.
5. I promise to pay all charges and expenses incurred in my treatment, including those expenses not covered by any insurance policy presently in force, including any co-payment and/or deductible. Unpaid accounts shall bear interest at the maximum rate provided by Florida law. If Impact Health and Performance is required to bring legal action to enforce payment, it shall be entitled to recover from me its attorneys’ fees and costs of collection in addition to the amount owed for the services.

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witnessed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_