Kalamazoo Functional Rehab Team

AUTHORIZATION TO BILL/CONSENT FOR TREATMENT PHYSICAL THERAPY SERVICES

Patient Name: _____ Date of Birth _____ Claim #_____

CONSENT FOR TREATMENT

The undersigned voluntarily CONSENTS TO, AND AUTHORIZES, such **Physical Therapy** evaluation and treatment as licensed/directed by the **Physical Therapist** at *Kalamazoo Functional Rehab Team* considers necessary and per the agreed upon Plan of Care.

A plan of treatment, including goals of treatment, is developed by the therapist(s) and patient together after an initial evaluation is performed. This Plan of Care is sent to the referring physician, physician assistant or nurse practitioner for review. The patient acknowledges that no guarantee has been given as to the outcome of this physical therapy plan of care.

ASSIGNMENT OF INSURANCE BENEFITS

In the event that the patient is entitled to insurance payments for *Kalamazoo Functional Rehab Team* services arising out of any policy of insurance for the patient or any other party to the patient, these benefits are hereby assigned to *Kalamazoo Functional Rehab Team for application against the patient's bill for services.* The undersigned and/or the patient agree to be responsible for any charges not covered by their insurance when applicable.

PROPERTY DAMAGE

In consideration for the health treatment being provided by *Kalamazoo Functional Rehab Team,* the undersigned hereby releases *Kalamazoo Functional Rehab Team* from any and all claims, demand, and causes of action involving any and all damages to property by *Kalamazoo Functional Rehab Team* agents or employees acting within the scope of their employment, except that caused solely by negligence.

TERMINATION

I understand this agreement may be terminated by giving at least 4-hour notice or as specified by regulation, whichever is longer. Additionally, *Kalamazoo Functional Rehab Team* may terminate this agreement by providing at least 72 hours or such other minimum notice required by applicable state law, except emergency terminations by either party for any reason.

- **BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE CONTENTS AND AM COMPETENT TO EXECUTE IT OR IF EXECUTED ON BEHALF OF ANOTHER, I AM AUTHORIZED TO EXECUTE IT ON BEHALF OF THAT PERSON.**

Signature of patient or patient Representative: _____ Date: _____

Relationship and Printed Name if a patient representative: _____

Witnessed by Kalamazoo Functional Rehab Team agent: _____

Rev/ver 3-2025