

AUTHORIZATION AND CONSENT

I hereby consent to all evaluation and treatment to be provided by the registered physical therapist as deemed necessary by my physician.

I hereby authorize the release of all information regarding my medical history, finding, and treatment to any insurance company, adjuster, attorney, or physician that may be involved.

I hereby authorize payment directly to Bright Bay Physical Therapy for professional services rendered and shall be personally responsible for any deductible, co-insurance payment and unpaid balance after insurance reimbursement.

Signature _____

Witness _____

Date _____

MEDICARE AUTHORIZATION AND CONSENT

I hereby consent to all evaluation and treatment to be provided by the registered physical therapist as deemed necessary by my physician.

I hereby authorize the release of all information regarding my medical history, finding, and treatment to any insurance company, adjuster, attorney, or physician that may be involved.

I hereby authorize payment directly to Bright Bay Physical Therapy for professional services rendered and shall be personally responsible for any deductible, co-insurance payment and unpaid balance after insurance reimbursement.

Signature _____

Witness _____

Date _____