

**IVYREHAB**  
**PHYSICAL THERAPY**  
**CONSENT FOR OUTPATIENT TREATMENT**

1. **AUTHORIZATION:**

- a. I hereby authorize **IVYREHAB'S** health care professionals and students to provide such medical care and to administer such treatment, necessary to the named patient or me each time I or the named patient present to an ambulatory care service. Such procedures and treatments may include, Physical Therapy, Occupational Therapy & Speech Therapy. To the extent possible I have been informed of risks and complications that may occur and alternatives that may be available.
- b. I acknowledge that no guarantees or assurances have been made to me concerning the results intended from my treatment.

2. **MEDICARE PATIENTS:**

- a. I authorize any holder of medical or other information about me to be released to the Social Security Administration, its intermediaries, carriers and information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

3. **GUARANTEE OF ACCOUNT:**

- a. For and in consideration of services rendered to (name) \_\_\_\_\_ by **IVYREHAB**. I hereby agree to pay the full bill for all charges which are not paid to **IVYREHAB** by insurance carriers, Worker's Compensation, No-fault or any balance due which is not covered by insurance or excluded by a co-insurance clause.

4. **RELEASE OF INFORMATION:**

- a. I permit **IVYREHAB** to disclose all or part of the above patient's medical records to any person, corporation, or agency when required for the collection of benefits or payment of **IVYREHAB** charges.

5. **ASSIGNMENT OF BENEFITS:**

- a. I assign to **IVYREHAB** all benefits from any corporation, agencies and person for these services. Additionally, I authorize payments of these benefits directly to **IVYREHAB**.

6. I confirm that I have read and fully understand the above.

Site Location: \_\_\_\_\_

Patient/Relative or Guardian: \_\_\_\_\_  
(Signature) (Print name)

Relationship (if signed by person other than patient) \_\_\_\_\_

(If Required) Interpreter: \_\_\_\_\_  
(Signature) (Print name)

Witness: \_\_\_\_\_  
(Signature) (Print name) (Date)