TIM FOLEY PHYSICAL THERAPY
1700 12th Street, Suite C
Hood River, OR 97031
Office (541) 386-9735
Fax 541) 386-2015

CONSENT FOR MEDICAL TREATMENT

I hereby authorize Tim Foley Physical Therapy to administer and perform procedures deemed necessary or advisable in the treatment of this patient, as authorized by the attending physician.

AUTHORIZATION FOR RELEASE OF INFORMATION

I further authorize Tim Foley Physical Therapy to release the necessary information requested for insurance or legal purposes, or as requested by authorized physician. I also authorize release of information from physicians or other health care facilities to Tim Foley Physical Therapy as needed for physical therapy records.

I recognize that the information disclosed may contain information that is protected by federal and state law, and I specifically consent to disclosure of such information.

AGREEMENT FOR FINANCIAL RESPONSIBILITY

I hereby authorize payment directly to Tim Foley Physical Therapy, by my insurance carrier, of benefits otherwise payable to me, such payment not to exceed Tim Foley Physical Therapy's regular charges for the services performed. I understand I am financially responsible to Tim Foley Physical Therapy for charges not paid under this agreement.

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Patient Signature Parent/Guardian Signature

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Date