



Consent to Physical Therapy

1. CONSENT TO TREATMENT: I consent to rehabilitation and related services at Symmetry Physical Therapy. In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature.

2. TREATMENT OF MINORS: I, as a parent/guardian of a minor receiving treatment here under, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive and claim I may have resulting from failure to do so.

3. LIABILITY: I know and agree that Symmetry Physical Therapy is not responsible for loss or damage to personal valuables.

4. WAIVER AND RELEASE: I hereby release, discharge and acquit Symmetry Physical Therapy, it's agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept receive or allow emergency and or medical service, including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services.

5. AUTHORIZATION OF PAYMENT: I hereby assign all benefits directly to Symmetry Physical Therapy and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. *I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.*