RehabVisions
PHYSICAL THERAPY & SPORTS MEDICINE

1010 Robert Bush Drive West
South Bend, Washington 98596
360-875-5543

CONSENT FOR TREATMENT

I, the undersigned, hereby agree and give my consent to RehabVisions to administer such treatment and care as is prescribed and considered therapeutically necessary on the basis of findings during the course of treatment.

I also authorize RehabVisions to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for the services rendered.

The information provided is accurate to the best of my knowledge.

_____

Patient Name *(please print)*:

_____ _____

Signature **Date**

_____

Relation *(self, parent, guardian, etc.)*