Name_____

Date_____

Redbud Health Services
500 E 3RD ST
Buchanan, MI 49107

Phone: (269) 409-8626
Fax: (269) 273-8457

Redbud Health Services
Physical Therapy Admission Consent Form
(Please initial each line)

_____**Consent to Treatment:** I Consent to rehabilitation and related medical services from Redbud Health Services Physical Therapy Clinic.

_____ **Release of Information:** I allow Redbud Health Services to give information related to me and any third-party payer or insurance company which may be responsible in whole or in part for paying my bill to companies hired by these third parties to monitor utilization or rehabilitation service, and to any health care facility or physician by which I am referred or who I have identified and my primary care provider.

_____**Acknowledgment of Precipitation:** I hereby release Redbud Health Services/ Redbud Lifestyle and Fitness Center from any responsibility or liability due to my participation in physical therapy. I am fully aware that I am participating in these sessions at my own risk and will not hold those named above responsible in the event of my incurring an injury or exacerbating any previously existing conditions. If I have any medical conditions, I have consulted with my physician to make sure that physical therapy is appropriate for me to participate in.

_____ **Authorization of Payment:** I hereby assign all benefits directly to Redbud Health Services and authorize release of any medical record necessary to facilitate my treatment to process medical claims and as otherwise permitted or required by Notice of Privacy Practices. I understand that in the event my insurance company or financial responsible party does not pay for the services I receive, I will be fully responsible for payment.

_____ **Notice of Privacy Practice:** I acknowledge that I have been provided with and offered a copy of the Notice of Privacy Practice. (attached)