

971 Route 202n, Suite #2 Branchburg, NJ 08876 Tel: 908-255-4040

Fax: 908-845-8649

Authorization & Consent for Treatment

in in the state of	, , , , , , , , , , , , , , , , , , , ,
I consent to Align Physical Therapy and Wellness for treatments/procedures that are necessary or advisable for my care. I authorize Align Physical Therapy and Wellness to exchange with and/or release requested information on my medical care to my insurance carrier and any other parties involved in your case	
Patient's Signature	Date
I certify that the information furnished by me is correct and hereby direct and authorize payment of health care benefits due by my insurer to Align Physical Therapy & Wellness. I understand that I am financially responsible for payment of fees regardless of insurance coverage. I also certify that I have received the initial patient information from Align Physical Therapy and Wellness.	
Patient's Signature	Date
I have read and understood Align Physical Therapy and Wells copy of this privacy notice upon request.	ness' privacy notice. I further that I may obtain a
Patient's Signature	Date
I have read and understand Align Physical Therapy and Welli Policy, cancellation and no-show policies. I further understan request.	<u> </u>
Patient's Signature	Date

Date

Parent or Guardian Signature (if patient is a minor)