

Andrus Physical Therapy, LLC
Pediatric Center
804 West Park Avenue, Bldg C
Ocean, NJ 07712
Phone: (732) 493-1166 Fax: (732) 493-1188

CONSENT TO PHYSICAL THERAPY TREATMENT

PATIENT NAME: _____ **DATE:** _____

- 1. I have presented myself for physical therapy treatment to Andrus Physical Therapy, LLC and consent to examination and treatment provided by my attending physical therapist.**
- 2. I have the right to refuse or decline any examination, treatment, or procedures to the extent permitted by law in the state of New Jersey. I acknowledge the medicine/physical therapy is not an exact science; no guarantees or warranties can be made regarding the result(s) of my treatment at Andrus Physical Therapy, LLC.**
- 3. I consent the release of copies of my examination and/or treatment records to referring physician(s) and/or third party payer (insurance companies) for the sole purpose of communication between Andrus Physical Therapy, LLC and the referring physician(s) and in order to properly process claims associated with my treatment. I also understand that I must give separate, written consent to allow Andrus Physical Therapy, LLC to release copies of my treatment records to any other parties (attorneys, non-referring physicians, etc.)**

PATIENT SIGNATURE: _____ **DATE:** _____

If patient is a minor or unable to consent:

RESPONSIBLE PARTY SIGNATURE: _____ **DATE:** _____

RELATIONSHIP TO PATIENT: _____

REASON UNABLE TO CONSENT: _____