TRI-STATE PHYSICAL THERAPY

CONSENT FOR TREATMENT

Patient's Name:_____ Date:_____

I hereby authorize the therapists at Tri-State Physical Therapy to perform the treatments or procedures approved by my referring physician.

I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and/or procedures. I fully understand that it is impossible to make any guarantees regarding the outcome of any medical treatment or procedure.

_____

(Authorized Signature) (Date)