Authorization

I authorize Physical Therapy Central, INC to release any information acquired in the course of my treatment necessary to process insurance claims or to discuss my treatment with other practitioners.

I authorize benefits to be paid on my behalf to Physical Therapy Central, INC for physical therapy treatment.

I am aware that I am responsible for deductibles, co insurances and any non covered services.

Patient Signature _____ Date: _____

Privacy Notice

By signing this form, I acknowledge that PTC, INC has provided me with a copy of its' Privacy Notice, which explains how my health information will be handled in various situations.

I understand that I may discuss my concerns and or any questions I have concerning this Privacy Notice with the PTC, INC representatives.

Patient Signature _____ Date _____

Email Information

We would like to have your Email Address so that we may send you our Monthly Newsletter.

If you don't have an Email Address or you would rather not provide it to us; please specify below:

Email Address: _____