PT Unlimited, Inc
4146 Library Rd
Suite 1A
Pgh, PA 15234

CONSENT TO TREATMENT

PATIENT NAME: _____ **DATE OF BIRTH**: _____

__ I authorize and consent to physical therapy services which are necessary or beneficial.

__ I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees are made as to the results of the procedures performed or treatments received by physical therapists of **PT Unlimited, Inc**. .

__ I consent to the release of all information from the medical record to the government, utilization review and accrediting agencies having responsibility for the oversight of healthcare providers.

__ I consent to the photographing or videotaping of evaluation and treatment procedures to be performed. To the extent that such photographs and/or videotapes are for scientific or educational purposes only, I understand that the photographs will not become part of my/the patient's medical record.

__ I consent to treatment at this facility. I understand that I may choose among providers of care and can opt to receive therapy services at/by another facility.

__ I have read this form (or have had it read to me) in its entirety, have had any questions answered to my satisfaction and am signing this form knowingly and voluntarily.

Consent to Evaluation and Treatment:

By my signature below, I certify that the information I have provided is complete, accurate and truthful to the best of my knowledge, and I consent to the evaluation and treatment of my condition by **PT Unlimited, Inc** licensed physical therapists.

_____ _____

Patient signature/responsible party signature **Date**

_____ _____

Witness/PT Unlimited, Inc. employee signature Date