



# FOLSOM PHYSICAL THERAPY *and Training Center*

## Consent to Treat

---

Were you injured on the job?	YES	NO
Have you filed a work comp claim?	YES	NO
Were you injured in a motor vehicle accident?	YES	NO
Is this injury involved in litigation?	YES	NO

If you have an attorney, please fill out the following:

Name of Attorney: \_\_\_\_\_ Phone#: \_\_\_\_\_

Address: \_\_\_\_\_

**\*We do not accept liens against pending legal settlements.**

Missed appointments are a loss for everyone. Please notify us as soon as possible if you cannot keep your scheduled appointment. We require **(a minimum) 24-hour cancellation notice** to allow us time to fill your appointment time. **Cancellations or missed appointment (“no shows”) without at least a 24-hour notification are subjected to a \$25.00 fee.**

I, \_\_\_\_\_, have read and understand that I remain responsible for  
(PRINT NAME HERE)

the total amount due to Folsom Physical Therapy for their services and policies, such as that listed above. I, the undersigned, do hereby agree and give my consent to Folsom Physical Therapy to furnish medical care and treatment considered necessary and proper in assessing or treating my physical condition.

I hereby assign all medical benefits to Folsom Physical Therapy and authorize release of all information necessary to secure payment. A photocopy should be considered valid.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_