FIRST STEP PHYSICAL THERAPY
900 WALT WHITMAN ROAD, SUITE 310
MELVILLE, NEW YORK 11747

Assignment of Benefits

I authorize the release of medical information to process this claim and authorize payment of medical benefits to First Step Physical Therapy for services described on my explanation of benefits statement.

Signed:_____ Date:_____

Payment Policy

All accounts including co-insurance and co-pay are due at the time of service, unless other arrangements are made with the billing department.

I understand and agree that regardless of my insurance, I am ultimately responsible for the balance of my account for any professional therapy services rendered.

Signed:_____ Date:_____

Consent to Treatment

I understand that I have been referred for physical therapy and rehabilitative treatment care at First Step Physical Therapy. First Step Physical Therapy will describe to me my individual treatment plan. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including any risks or alternatives to the treatment plan that has been prescribed for me. By signing this agreement, I consent to have First Step Physical Therapy provide treatment and care as prescribed by my physician and/or recommended by my physical therapist.

Signed:_____ Date:_____

Relationship to Patient:_____
(self, parent, legal guardian, spouse, etc.)

Witness:_____