

**STOVER PHYSICAL THERAPY
CONSENT TO TREAT and NOTICE of PRIVACY PRACTICE**

I hereby request and consent Stover Physical Therapy, PC to perform rehabilitative services as prescribed by my physician and/or recommended by my physical therapist. I authorize Stover Physical Therapy, PC to release any information acquired in the course of my treatment necessary to process insurance claims or to discuss my treatment with other healthcare providers.

I authorize benefits to be paid on my behalf to Stover Physical Therapy, PC for rehabilitative services.

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

I acknowledge receipt of the Stover Physical Therapy notice of privacy practice.

Patient Name: _____

Patient Signature: _____

Date: _____