



**P R E M I E R**  
**PHYSICAL THERAPY**

*Where it's all about you... all the time.*

**Conditions of Admission**

Premier Physical Therapy and Wellness, Inc. may disclose all or any part of your record to any person or corporation which is, or may be, liable under a contract to Premier or to the patient. We can also release to a family member or employer of the patient for all or part of Premier Physical Therapy's charges, including but are not limited to, hospital or medical service companies, insurance companies, workman's compensation carriers and/or welfare funds.

I authorize the Social Security Administration to disclose information regarding my Medicare coverage, including but not limited to, verification of my Medicare number, effective dates and type of coverage to Premier Physical Therapy. I also request payment of government benefits and all medical benefits to Premier Physical Therapy.

\_\_\_\_\_  
Initial

\_\_\_\_\_  
Date

The patient is under the control of his/her physician and the undersigned consents to treatment or procedures rendered to the patient by Premier Physical Therapy under the general and specific instructions of the physician. It is further understood that Premier Physical Therapy is authorized to carry out all instructions of the patient's doctor and that Premier Physical Therapy is hereby relieved of any and all liability from the performance of the doctor's instruction. I request and authorize the staff at Premier Physical Therapy to provide me with treatment and to perform any procedures now contemplated or such additional procedures as my doctor may deem reasonable and necessary.

\_\_\_\_\_  
Initial

\_\_\_\_\_  
Date

Premier Physical Therapy provides treatment to its patients in the most efficient and effective manner possible, as opposed to only providing the modalities allowed and reimbursed by the patient's insurance company. Deemed medically necessary, the physical therapy treatment will be billed by Premier Physical Therapy AS A COURTESY, but there may be certain supplies and services not covered in the patient's insurance contract. The undersigned agrees to be fully responsible for **all costs not paid for by third-party payers.**

The undersigned certifies that he/she has read the forgoing and is the patient, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

This request is to remain in effect for one (1) year unless otherwise revoked.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Person in Lieu of Patient

\_\_\_\_\_  
Reason why patient is unable to sign

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Witness: person securing request

\_\_\_\_\_  
Date