



CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for **ADVANCED PHYSICAL THERAPY** to furnish medical care and treatment to _____ (individual receiving treatment) considered necessary and proper in diagnosing or treating his/her physical and mental condition.

Patient/Guardian _____ **Date** ____/____/____

APT personnel are authorized to: (please initial in each area of response)

Leave message on answering machine regardless of who hears it: Yes _____ No _____
Leave message with anyone who answers the phone: Yes _____ No _____
Leave message or talk to anyone under any condition: Yes _____ No _____
Leave message or talk to anyone at any time: Yes _____ No _____

Specify (other than patient) who can take messages or release information about patient:

What access code can we use to be sure of speaking to person listed above?

Email Address: _____

APT personnel is authorized to call patient at **work** (please initial in each area of response)

About Appointments: Yes _____ No _____
About account problems: Yes _____ No _____

APT personnel are authorized to call or fax patient data to **treating physician, PCP, and/or Assistant:*** Yes _____ No _____

Specify Physicians Authorized

APT personnel are authorized to communicate to insurance company about patient's account: (please initial response area) * Yes _____ No _____

***By Texas Law it is required to communicate with treating physicians and insurance companies or the representative who covers your claim for workers compensation.**