

## CONSENT FOR TREATMENT

I hereby consent to treatment at Lakeview physical therapy as recommended by my physician.

I hereby authorize Lakeview Physical Therapy, P.C. to release information related to insurance claims. I understand that it is my responsible for verifying coverage with my insurance company.

**I am financially responsible for charges incurred and payment will be made on the day that services are rendered\*\*.**

\*\*Does not apply to BCBS PPO members

This signed document assigns benefits to Lakeview Physical Therapy, P.C. for BlueCross BlueShield PPO members only.

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Print name

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Signature of Patient

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Date