Release of Information and Consent to Treat

I, _____ (patient name), give permission for *I Can Therapy* to give me medical treatment. I understand that this care can include an evaluation, testing and treatment. No guarantees have been made to me about the outcome of this care.

I give permission *to I Can Therapy* to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, and related healthcare provider, as it relates to my treatment or payment for services provided.

I have received a copy of Privacy Practices for I Can Therapy.

I allow *I Can Therapy* to file for insurance benefits to pay for the care that I receive.

I understand:

- *I Can Therapy* will have to send my medical record information to my insurance company.
- I must pay my share of the costs.
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

I understand:

- I have the right to refuse any treatment.
- I have the right to discuss all medical treatments with my therapist.

_____ _____

Patient's Signature Date

_____ _____

Parent or Guardian Signature (if under 18) Date

_____

Print Name