Patient Consent for Treatment

I do hereby voluntarily consent to such treatment as is deemed necessary by my referring physician and physical therapist. I hereby release Louisiana State University Health Sciences Center and its personnel from any responsibilities resulting from illness, ill effect, or reaction from the treatment ordered by my physician.

Patient Payment Guarantee and Authorizations

In consideration for and to cause Louisiana State University Health Sciences Center Physical Therapy Clinic to treat _____ (print name of patient) as a private patient, the undersigned hereby unconditionally guarantees payment of all cost charges and expenses of the Louisiana State University Health Sciences Center Physical Therapy Clinic (LSU PT Clinic) to apply for benefit on my behalf for covered services rendered by the LSU PT Clinic, and request all payments be made to "LSUHSC". Furthermore, I understand and agree any unpaid balance not covered by my insurance policy will be paid directly by me.

Insurance forms are to be mailed to: (Please indicate with a X)

- Employer ☐
- Insurance Company ☐
- Other (Specify) ☐ _____

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care procedures. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I have read all of the above, and I certify that I understand its contents.

_____ _____
Patient's Signature Date

_____ _____
Other Authorized Signature (if patient cannot sign) Date

_____ _____
Relationship of Authorized Signature Reason patient cannot sign

In case of emergency, please contact:

_____
Name/Relationship

_____
Telephone Number