

WELLINGTON[®]

Orthopaedic & Sports Medicine

Physical Therapy / Hand Therapy Treatment Authorization

I hereby give consent to receive physical therapy / hand therapy
I hereby give consent to have my child receive physical therapy / hand therapy
by Wellington Orthopaedic and Sports Medicine.

I understand I am financially responsible for the costs of all services provided to me
including the balance remaining after payment of possible insurance benefits.

I understand Wellington Orthopaedic and Sports Medicine has verified insurance benefits
available to me and I have received a copy of their form reflecting such coverage. I
understand that the verification provided by my insurance company to Wellington
Orthopaedic and Sports Medicine is not a guarantee of coverage. I understand my
payment may be higher if the information obtained by Wellington Orthopaedic and
Sports Medicine is not correct.

I understand that my Physician has referred me to therapy for specific treatment and
goals. It is my responsibility to perform as instructed by my therapist and remain in good
standing in regards to attendance, which will result in the best outcome for me as a
patient. I also understand that therapy may initially increase my current level of pain and
it is my responsibility to communicate all issues and concerns to my therapist.

Patient/Guardian Signature _____

Date ____/____/____