AUTHORIZATION FOR EXAMINATION / TREATMENT

DATE

I Mr./Mrs./Miss -------------------------------- the patient in this office here by authorize provider of Quality Care Physical Therapy & Rehab center, PA to administer examination/treatment as necessary to provide therapy or procedures as are considered therapeutically necessary on the basis of findings during the said course of examination/treatment.

I hereby certify that I have read and fully understand the above authorization for physical therapy examination/treatment. Its advantages and possible complications, is any as well as possible alternate modes of treatment are explained to me by provider of this clinic.

Patient name (please print)

----

patient signature