

Progressive Rehabilitation Solutions, LLC

CONSENT TO TREAT

Customer Name: _____ DOB _____

Service Site: _____

Section I - Consent for Treatment and Customer Bill of Rights

I, the undersigned, authorize Progressive Rehabilitation Solutions, LLC to perform the examination, tests, treatments that are considered necessary for my care. I agree to work with Progressive Rehabilitation Solutions, LLC to maximize my progress towards mutually established treatment goals which have been authorized by my physician. I also agree that no guarantee or assurance has been made as to the results that may be achieved from these services.

I, the undersigned, warrant I have read the Consent for Treatment above and also warrant that I have full authority to authorize the above Consent for Treatment which I have read and approved, intending to be legally bound.

I, the undersigned, intending to share records and information with third parties participating in my rehabilitation, including any party which through an insurance program or otherwise is paying for all or part of my rehabilitation. I authorize Progressive Rehabilitation Solutions, LLC to act on my behalf with any reasonable and necessary appeals in regard to services provided by Progressive Rehabilitation Solutions, LLC.

Signature: _____ Date: _____

Witness: _____ Date: _____

Section II - Assignment of Benefits to Progressive Rehabilitation Solutions, LLC

I authorize payment of medical benefits to be made directly to Progressive Rehabilitation Solutions, LLC for the aforementioned services. I understand that any portion not covered by insurance will be my responsibility.

Signature: _____ Date: _____

Witness: _____ Date: _____

If any of the above is signed by a responsible party due to the incapacity of the customer, please state the relationship of the responsible party to the customer below:

Signature _____ Date: _____