1180 Cross Street SE
Salem, OR 97302
503.339.7781

MEDICALLY INFORMED CONSENT AND ASSIGNMENT AND RELEASE

I voluntarily consent to physical therapy treatment and services deemed necessary by my physical therapist and /or physician. I am aware that the practice of physical therapy is not an exact science and I acknowledge that no guarantees have been made to me as to the results of these services at the Rejuvenation Therapy Pain Clinic. It is this clinic's sincere intent to educate me on every process, from billing to treatment and eventually discharge from services.

Therefore, if techniques that are being used to retrain, recruit & restore postural alignment are not understood, it is my responsibility to obtain a clearer understanding of what the therapist's objectives and outcomes are, and how he/she is trying to achieve them
This consent shall be ongoing for a period not to exceed **one year**.
I hereby authorize my insurance benefits be paid directly to Rejuvenation Therapy Pain Clinic, and understand that I am financially responsible for non-covered services. I understand that if
Rejuvenation Therapy Pain Clinic does not contract with my insurance company; I will be responsible for the difference between what is charged and what my insurance pays. I also authorize Rejuvenation Therapy Pain Clinic to release any information necessary in order to process this claim. All of the information provided is correct and true to the best of my knowledge. **I am responsible for all charges incurred at Rejuvenation Therapy Pain Clinic.**

I, _____,
(print patient name)
have read this form and fully understand and accept its terms and conditions.

_____ _____ _____
Signature (Patient or person authorized to consent for patient) Relationship Date