



## Consent for Treatment

I, \_\_\_\_\_, authorize Capstone Physical Therapy and its employees to provide me with medical treatment as deemed appropriate by Capstone Physical Therapy and/or my referring physician.

I further allow for emergency medical treatment and/or 911 to be called on my behalf in the event of a medical emergency.

Capstone Physical Therapy is committed to protecting your medical information. We will provide a copy of our Privacy Policy upon your request.

I authorize the release of any medical or other information necessary to my primary and referring physicians or anyone involved in my medical care for this or any related diagnosis.

I authorize Capstone Physical Therapy to release any information acquired in the course of my treatment to my insurance company for completion of processing my claim.

\_\_\_\_\_  
Patient Signature (or authorized party)

\_\_\_\_\_  
Date