Inspired Mobility Physical Therapy, LLC

Name_____ Date_____

Direct Access Disclaimer

My physical therapist has explained that evaluation by him/her is not a medical diagnosis. I understand that an evaluation by a Physical Therapist is not a medical diagnosis by a physician or based on any radiological imaging; therefore, it may not be covered under medical expenses by my insurance company.

_____ _____

Client Signature Date

Consent to Treatment

I give permission to my physical therapist to evaluate and treat me today with/without a physician's prescription and/or medical diagnosis.

_____ _____

Client Signature Date

Financial Responsibility

I assume financial responsibility for payment of services at time of service as I am aware that Inspired Mobility Physical Therapy, LLC is an out of network provider.

_____ _____

Client Signature Date

_____ _____

Witness Date