Therapy Treatment Consent Form

Patient Name: _____ **Date of Birth:** _____

Therapy Services have been ordered by: _____

- ☐ **Occupational Therapy**
- ☐ **Physical Therapy**
- ☐ **Speech Therapy**

It is important that you understand the purpose and need for therapy. If you have any questions regarding this therapy, please feel free to consult your evaluating therapist(s), or you may call your physician.

I authorize Stellar Rehabilitation, LLC to provide therapy services according to the proposed plan of care provided by the evaluating therapist(s). I agree to the use of personal information with regards to my therapy treatment and plan of care provided by Stellar Rehabilitation, LLC. I further authorize the sharing of information with my physician(s) and insurance company(s) when appropriate for determining treatment, eligibility and coverage for therapy services provided.

Stellar Rehabilitation, LLC will file all claims to your insurance company for payment of services provided. However, I understand that I will be responsible for the cost of services of which my insurance company(s) does not cover or reimburse. Stellar Rehabilitation, LLC will make every effort to obtain prior authorization for services from your insurance carrier; ultimately it will be your responsibility to pay for services not authorized or approved by your insurance carrier.

_____

Print Name of Responsible Party (Patient/Parent/Guardian)

_____ _____

Signature **Date**