PORTSMOUTH
1 Cate Street | Portsmouth, NH 03801
P: 603-431-0277 | **F:** 603-422-8849

DOVER
60 Pointe Place, Suite 1 | Dover, NH 03820
P: 603-740-1300 | **F:** 603-740-0060

PATIENT CONSENT FORM

Name: _____ Date of Birth (MM/DD/YR): _____ / _____ / _____

Medical Consent
The patient is under the control of his/her physician's care and Lighthouse Physical Therapy, LLC.

Release of Information *(Please initial all that apply below)*

_____ (Initials) I acknowledge that Lighthouse Physical Therapy, LLC is committed to improving my health and may utilize information gathered from referring physicians.

_____ (Initials) I acknowledge that Lighthouse Physical Therapy, LLC will use my information for the purpose of treatment and payment.

_____ (Initials) I acknowledge my health care information will be disclosed for purposes of communicating results and findings to my physician.

_____ (Initials) I acknowledge that I have been given a copy of the ***"Notice of Privacy Practices"*** form from Lighthouse Physical Therapy, LLC. ***(This is most often waived on the Notice of Privacy Practices)***

Assignment of Individual Benefits
The undersigned hereby assigns to Lighthouse Physical Therapy, LLC any and all rights and benefits they may have under any policy of insurance, automobile, worker's compensation or any other policy. I hereby authorize Lighthouse Physical Therapy, LLC to release whatever medical information is necessary to our third party billing agency to perfect a claim under such policy and further direct any payables to Lighthouse Physical Therapy, LLC and authorize such to submit a claim to Medicare (if applicable) for payment.

_____ _____
Signature of Patient/Legal Guardian (if patient under 18) Date