

Lighthouse Physical Therapy, LLC.

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Portsmouth, NH 03801
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Fax: (603) 422-8849

42M Dover Point Road
Dover, NH 03820
Phone: (603) 740-1300
Fax: (603) 740-0060

Patient Consent Form

Name: _____ Date of Birth (M/D/YR): _____

Medical Consent

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

Release of Information

I acknowledge that Lighthouse Physical Therapy, LLC is committed to improving my health and may utilize information gathered from referring physicians. **(Please initial all that apply below)**

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

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

_____ **I acknowledge that I have been given a copy of the "Notice of Privacy Practices" form from Lighthouse Physical Therapy, LLC.**

_____ **I acknowledge that I have refused a copy of the "Notice of Privacy Practices" form from Lighthouse Physical Therapy, LLC.**

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.

Patient/Guardian Signature

Date