1105 Independence Drive
West Plains, Missouri. 65775
Phone: 417-372-8090
Fax: 417-256-0882

CONSENT TO TREAT

The undersigned consents to receive health care and/or wellness services by Progressive Therapy Solutions, LLC health care practitioners. Payment is expected at time of services rendered and is the responsibility of the client. Clients may submit charges to their insurance carrier, with the understanding that services may or may not be covered.

_____. _____

Patient Signature / Parent or Legal Guardian **Date**

_____.

Printed Name

CONSENT TO RELEASE / RECEIVE MEDICAL RECORDS

Your doctor or insurance company many request your medical records. Likewise, it may be necessary or helpful for your therapist to review another provider's records on you. The following gives Progressive Therapy Solution, LLC personnel the authorization to send or receive your records.

Please check one:

_____ I authorize Progressive Therapy Solutions, LLC to RELEASE my medical records to:

Facility Name:_____
Physician/Diagnostic depart:_____
Phone:_____
Address:_____

_____I authorize Progressive Therapy Solutions, LLC to REQUEST my medical records from:

Facility Name:_____
Physician/Diagnostic depart:_____
Phone:_____
Address:_____

I hereby authorize Progressive Therapy Solutions, LLC to either release or receive my medical records including office notes, x-rays, operative reports, and any information regarding medical consultation and treatment I have received.

Patient Name: _____. Date:_____
Date of Birth:_____/_____/_____. Social Security Number:_____

Patients Signature:_____