

Physical Therapy Authorization Waiver



I understand that it is my responsibility to determine if my insurance company requires preauthorization for any necessary therapy.

If preauthorization is required, I understand that I must inform my physician's office of this requirement at the earliest possible date to allow sufficient time to process this request before the initial physical therapy appointment. **Failure to do so may result in nonpayment by my insurance company. In this case, I assume sole responsibility for payment.**

Today's Date:

Print Patient Name:

Patient's Date of Birth:

Signature of Patient or Parent/Legal Guardian:

Print Name of Parent/Legal Guardian: