KANSAS ORTHOPAEDIC CENTER P.A.
THERAPY DEPT

CONSENT FOR TREATMENT

Patients Name: _____ Date _____

MR# _____

I hereby authorize the therapists at this clinic to perform the treatments or procedures approved by my referring physician.

I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and/or procedures. I fully understand that it is impossible to make any guarantees regarding the outcome of any medical treatment or procedure.

(Authorized Signature) (Date)