Natural Physical Therapy
of East Amherst

Direct Access Consent Form

Patient Name: _____
Patient Address: _____
Physical Therapist: _____

I _____ understand that New York State allows physical therapy treatment to be provided without a referral from a physician, dentisti, podiatrist, physician assistant or nurse practitioner for 10 visits or 30 days.

Evaluation Date:_____ DA End Date:_____

I understand physical therapy treatment provided without a referral may not be covered by my health care plan and that this treatment may not be a covered expense if rendered pursuant to such referral. I agree to be responsible for any all charges not covered by my health care plan.

I understand that I am responsible if insurance does not pay.

Patient Signature & Date: _____

Physical Therapist Signature & Date: _____