Direct Access Consent Form

Patient Name: _______________________________

Patient Address: _____________________________

Physical Therapist: ___________________________

__________________________________ understand that New York State allows physical therapy treatment to be provided without a referral from a physician, dentist, 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 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: ______________________________