WEST BILLINGS
Physical Therapy & Sports Medicine
3307 GRAND AVENUE, STE 203 • BILLINGS, MT 59102-6551

CONSENT FOR TREATMENT

I voluntarily agree to receive treatment by the staff of West Billings Physical Therapy, either in person or via telehealth.

I understand and agree that I will participate in my treatment plan, and that I may discontinue treatment and/or withdraw my consent for treatment at any time.

I understand that staff of West Billings Physical Therapy may discontinue treatment at their discretion.

_____

Patient Legal Name – Please print

Patient DOB: _____

Current Address _____

_____

Current Phone # _____

Would you like an appointment reminder sent to your Email? If Yes, please print clearly

Email: _____

_____ _____

Patient (over 18) or Guarantor Signature Date