MARYLAND CENTER FOR PHYSICAL THERAPY

Jennifer J. Schlesinger, P.T.
President

Ian Fischer, M.P.T.
Joan Fairbank, M.P.T
Rebecca Ridgway, P.T.A.

CONSENT TO TREATMENT

FOR THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended medical or diagnostic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks involved. This disclosure is not meant to scare or alarm you, it is simply an effort to make you better informed so you may give or withhold your consent to the procedures.

I/We voluntarily request J. Schlesinger & Associates, P.A., and its licensed Physical Therapy providers, to evaluate my condition and explain their assessment and recommendations for treatment.

I/We understand that certain procedures will be planned for me and I/we voluntarily consent and authorize and evaluation and treatment.

I/We understand that my physical therapist may assess other or different conditions as treatment progress which may require additional and recommended different procedures than those initially planned. I/We authorize J. Schlesinger & Associates, P.A., and its licensed providers to perform or assist with such other procedures, which are advisable in my physical therapist's professional judgment.

I/We understand that no warranty or guarantee has been made to me as to result or cure.

I/We will be given an opportunity to ask questions about my condition and treatment, risks of non-treatment, the procedures to be used, and the risks and hazards involved, and can rescind consent if I/we believe that I/we do not have sufficient information to give this informed consent.

I/We certify this form has been explained to me if requested, or that I/we have read it, or have had it read to me and that I/we understand its contents.

_____

Patient/Legal Guardian (Date)

Authorization for Release of Medical Records

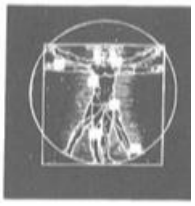
Date:_____

This is to authorize J. Schlesinger and Associates, P.A./Maryland Center for Physical Therapy to release any and all medical reports, test results, information or opinions regarding my physical condition or treatment rendered to me which the Maryland Center for Physical Therapy may deem necessary to my health care providers, insurance company, or attorney. This includes reports of MRI's, C.T. scans, x-rays, etc. or any medical records they may have in their possession, including medical reports, prescriptions, or referrals received from other health care providers regarding my condition or treatment.

This authorization is valid for a period of one year from the above date.

_____

Patient/Legal Guardian (Date)



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Hot/Cold Pack Disclaimer

I, _____, understand that heating pads can cause a second or third degree burn if they are too hot. Cold packs may also cause these types of burns. I understand that it is my responsibility as the patient to alert the treating Physical Therapist and/or the Technician if the heating pad and/or cold pack get too hot or cold. Patient safety is our first priority. Every effort is made to provide adequate padding to prevent a burn, but we must rely on you, the patient, to inform us if it is too warm or cold. Heat provided should be comfortable warmth and not be perceived as "hot."

The Maryland Center for Physical Therapy and/or J. Schlesinger and Associates, P.A. does not accept responsibility for injury resulting from any heating pad or cold pack. Please feel free to direct all questions and concerns to your therapist.

_____
Patient/Legal Guardian Initials

Attendance Policy

The attendance policy for the Maryland Center for Physical Therapy is as follows:
The patient must give our office 24 hours notice for cancelling an appointment.

After the patient cancels an appointment without proper 24 hour notice 1 time, the patient will be responsible for paying a $25.00 Cancellation Fee. If the patient fails to show for an appointment, the patient will be responsible for paying a $40.00 No-Show Fee.

If the patient fails to pay these fees, he/she will be taken off the schedule and will no longer be able to receive treatment at this facility until the fees are paid. Thank you for your compliance with this policy.

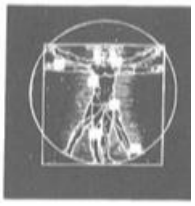
_____
Patient/Legal Guardian Initials

Receipt of H.I.P.P.A Pamphlet

I have received a pamphlet explaining my privacy rights by H.I.P.P.A. (Health Insurance Portability and Accountability Act). I understand my rights as stated in the pamphlet. Any questions about my rights were explained to me.

_____
Patient/Legal Guardian Initials

_____
Patient/Legal Guardian (Date)



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Assignment of Insurance Benefits and Financial Responsibility Guarantee

Patient Name:_____ Service Date:_____

I/We hereby assign any and all insurance benefits due and payable to me/us by any insurance policy to J. Schlesinger and Associates, P.A. for services rendered. I/We further understand and agree that this Assignment is non-revocable. I/We authorize and third party of their insurer, who admits to liability, or who is adjudged liable for my injuries, to pay benefits directly to J. Schlesinger and Associates, P.A.. Further, I authorize my insurance carrier any medical records or other documents requested by the carrier which are deemed necessary by the carrier may not be disclosed to any other party without my expressed written consent. I understand that any benefit quotes or coverage information given to us by any member of the staff, faculty, or representative or the provider is not guaranteed and is only what the provider has been told by my insurer, review agencies, and/or third-party payers. If I do not give immediate notice to the provider of any third-party (e.g., insurer or HMO) that may pay for services but requires preauthorization or timely filing, I agree to pay for any charges not otherwise paid.

In the event the undersigned receives services from J. Schlesinger and Associates, P.A. without providing a written authorization from his/her primary care physician prior to services being rendered in accordance with all charges not paid by the insurance carrier due to non-compliance on your part. I/We understand that I/we are financially responsible for charges not covered by this assignment.

I/We understand that I/we personally guarantee to be financially responsible to pay J. Schlesinger and Associates, P.A. for any and all charges not covered by this Assignment.

I/We understand that if this account is assigned to an attorney or collection agency for collection and/or suit, J. Schlesinger and Associates, P.A. is entitled to an additional thirty three percent (33%) of account balance for attorney's fees and cost of collection.

I/We hereby agree that the statute of limitations with respect to any claim for services provided will not begin until there is a denial in writing by me of any balance, claimed to be due and owing to J. Schlesinger and Associates, P.A..

As a Guarantor, I fully accept the medical services provided to the above-named patient as full consideration for my signing of this document.

I/We have read this document and execute it with full knowledge and understanding of its content.

I authorize J. Schlesinger and Associates, P.A. to initiate a complaint to the insurance commissioner for any reason on my behalf.

_____

Patient/Legal Guardian (Date)