



**REHABVISIONS**  
390 Western Avenue  
Marengo, IA 52301  
319-642-0223

## **CONSENT FOR TREATMENT**

I, the undersigned, hereby agree and give my consent to RehabVisions to administer such treatment and care as is prescribed and considered therapeutically necessary on the basis of findings during the course of treatment.

I also authorize RehabVisions to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for the services rendered.

The information provided is accurate to the best of my knowledge.

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**Patient Name** *(please print):*

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**Signature**

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**Date**

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**Relation** *(self, parent, guardian, etc.)*