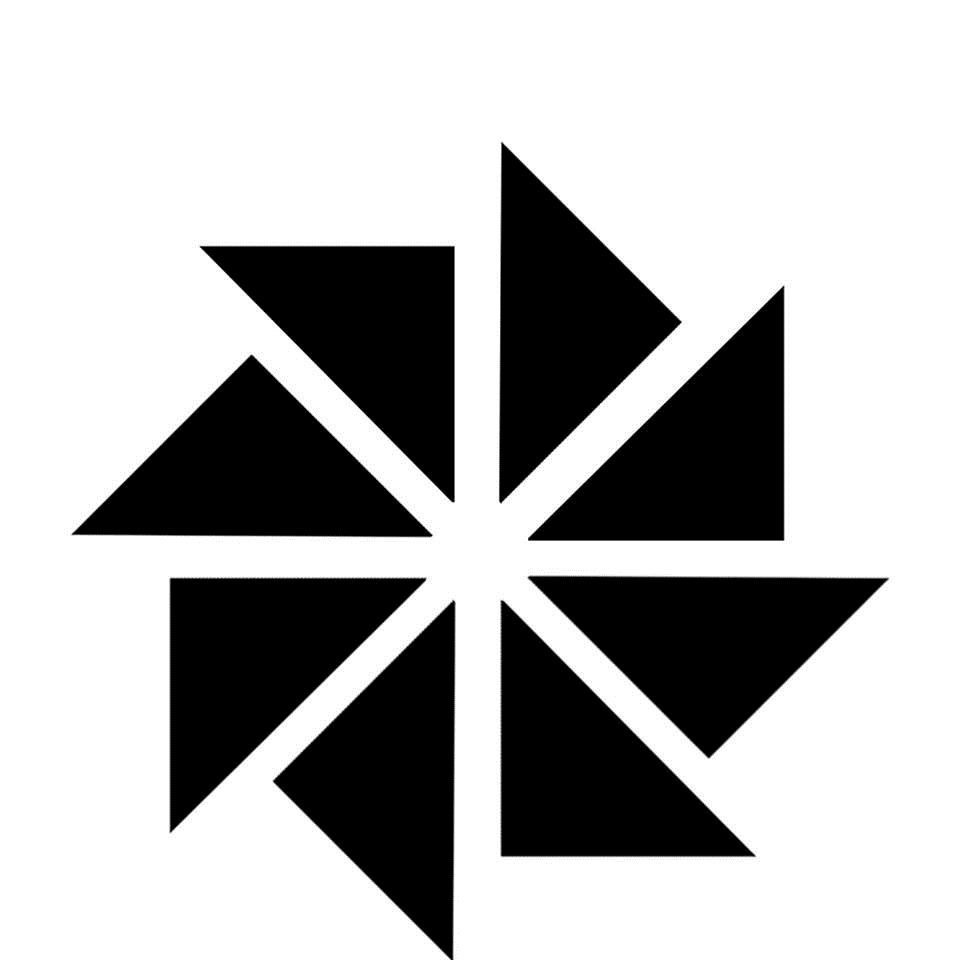
*PULMONARY REHABILITATION ASSOCIATES*



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330-758-7575 ● FAX 330-758-1833 ● E-MAIL: secondwindrehab.com

**Consent to Treatment**

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby acknowledge that I have received or was provided the opportunity to receive a copy of Pulmonary Rehabilitation Associates’ Notice of Privacy Practices. I furthermore authorize this physician to release any information acquired in the course of my examination or treatment and permit payment directly to him/her at his election, any benefits due me for his/her service. I recognize and accept my responsibility for any balance or fee not covered by my insurance plan, including my co-pay which according to my contract is due now.**

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**