

**PERFORMANCE PLUS**  
REHABILITATION CENTER

Patient Voluntary Consent for Treatment

Consent for treatment: It has been determined that I have a condition which warrants further medical and/or physical therapy follow-up. I have been given the option so receive care at the office of Performance Plus Rehabilitation Center or I may seek treatment with another physician/physical therapist of my choosing. I am aware that Performance Plus Rehabilitation Center is owned by Dr. Allyn Smith. I voluntarily consent to receive care at the office of:

Performance Plus Rehabilitation Center  
1802 N. Woodbine Road  
St. Joseph, MO 64506

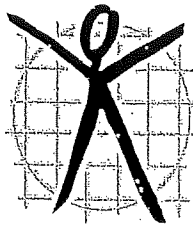
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Print Name

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Patient/Guardian Signature

Date



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Patient Name: \_\_\_\_\_  
Primary Care Provider: \_\_\_\_\_

I am allowing Performance Plus Rehabilitation Center, correspond with my medical doctor in regards to my condition and treatment plan.

Signed: \_\_\_\_\_  
Date: \_\_\_\_\_