AUTHORIZATION TO TREAT/ FINALNCIAL POLICY

****PLEASE INITIAL THE FOLLOWING:**

___ I HEREBY AUTHORIZE CURRENT PHYSICAL THERAPY TO PROVIDE TREATMENT AS PRESCRIBED BY MY PHYSICIAN.

___ I HEREBY ASSIGN ALL INSURANCE BENEFITS FOR SERVICES RENDERED TO WHICH I AM ENTITLED TO BE PAID DIRECTLY TO CURRENT PHYSICAL THERAPY. I UNDERSTAND THAT IF MY INSURANCE COMPANY/THIRD PARTY PAYER DENIES PAYMENT OR MAKES PARTIAL PAYMENT, THAT I AM RESPONSIBLE FOR THE BALANCE.

___ I HEREBY AUTHORIZE THE RELEASE OF MEDICAL RECORDS TO CURRENT PHYSICAL THERAPY AND ANY PERTINENT INFORMATION CONCERNING THE PATIENT FOR THE PROVISION OF CARE AND FOR OBTAINING INSURANCE REIMBURSEMENT.

___ I UNDERSTAND THAT I AM LEGALLY RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED BY CURRENT PHYSICAL THERAPY. IF MY INSURANCE IS BEING BILLED, I WILL BE RESPONSIBLE FOR PAYING ANY DEDUCTIBLE AMOUNTS. I UNDERSTAND THAT CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE. (THIS DOES NOT APPLY TO WORKER'S COMPENSATION PATIENTS.)

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

A. This office does follow the Notice of Privacy Practices. Initial_____

B. I agree to the open treatment area. Initial_____

C. I agree that, due to this open format, unauthorized individuals may read my name on the sign in sheet and may overhear personal health information. Initial_____

D. I agree that PT/PTA students may participate in my physical therapy care. Initial_____

Signature of Patient/ Guardian: _____Date: _____

Print Name: _____