TEAM™ PHYSICAL THERAPY P.C.

Together Empowering Able Movement

AUTHORIZATION AND CONSENT FOR TREATMENT

PATIENT'S NAME: _____ TODAY'S DATE: _____

I hereby authorize TEAM Physical Therapy, P.C. staff to administer all outpatient physical therapy treatments and procedures as deemed medically necessary.

I hereby authorize TEAM Physical Therapy, P.C. to provide copies of my physical therapy notes / medical record as requested by my insurance/assurance company, attorney or any other outside source representing me. I understand that I am responsible for the cost of postage/copying fees for these documents.

The following person(s) or organization(s) are authorized to receive my health information.
Name: _____Relationship: _____
Name: _____Relationship: _____

In the event of an emergency I request TEAM Physical Therapy, P.C. contact the following:

Name: _____ Phone: _____ Relationship: _____

I have been offered a copy of TEAM Physical Therapy, P.C. Notice of Privacy Practices, Bill of Rights & Responsibilities, and Financial Policy.

Do you want Statements Emailed instead of being mailed? **YES / NO**
_____ email (person responsible for account).

I authorize TEAM Physical Therapy, P.C. to have Waystar Payment Services send electronic account billing statements/invoices to my provided email address on file. I understand that I will not receive a copy of any such invoice via US Mail.

Do you want a Bank Card / Credit Card / or Health Savings Account card on file to pay balance on your account? **YES / NO**

If yes: *Please complete Automatic Payment Authorization form if enrolling in our auto pay program.*

I understand I am responsible for payment of all services rendered on my (or my dependent's) behalf. I will keep my account current and settle any discrepancies with my insurance company personally. I understand any unpaid balance on my account (after the due date) will incur a 1.33% monthly late fee charge (16% annual) that will be added to my outstanding balance that I am also responsible for. Missed payments may lead to my account being released to a collection agency. Any checks that bounce from my account may be turned over to the county attorney for collection. If a settlement or lawsuit is pending regarding your injury you will be responsible to make monthly payments on your account until balance is paid in full.

The undersigned has read and completed all the above information accurately.

Signed: _____OR_____
Patient (must be 19) Authorized person / relationship to patient
Date: _____ Time:_____ A.M. / P.M. Witness: _____