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.

I understand per the financial policy that my account to be paid in full within 6 months of the last date of service. If unable to pay within in 6 months I must contact the billing office promptly to discuss the account balance and set up a payment plan.

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: _____________________