PATIENT AUTHORIZATION

Patient Name_____ Date of Birth_____

CONSENT FOR TREATMENT & RELEASE OF INFORMATION

All information provided herein is true and correct.

I am aware of my diagnosis and wish to receive treatment at Marcotte Physical Therapy Inc. I permit its employees and other persons caring for me to treat me in ways they judge beneficial to me. I consent to rehabilitation and related services. I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching and/or direct contact of a sensitive nature. I understand that this care can include an evaluation, testing and treatment. No guarantees have been made to me about the outcome of this care.

I give permission to Marcotte Physical Therapy Inc. to release information, verbal and written, contained in my medical record and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment and/or payment for services provided.

I authorize Marcotte Physical Therapy inc. to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.

Initial_____

ASSIGNMENT OF BENEFITS

I authorize payment directly to Marcotte Physical Therapy Inc. for services and to bill and release payment directly to Marcotte Physical Therapy Inc. for any physical therapy, rehabilitation, orthotic or prosthetic service provided. This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original.

Initial_____

NOTICE OF PRIVACY PRACTICES (HIPPA ACKNOWLEDGEMENT/CONSENT)

I hereby acknowledge that I have received a copy of The Notice of Privacy Practices for Marcotte Physical Therapy Inc. In addition, I hereby consent to the use and disclosure of my personal health information for the purpose of treatment, payment, and health care operations.

Initial_____

PAYMENT GUARANTEE

I agree to pay Marcotte Physical Therapy Inc. for the services provided to me or the party named above. If any law, such as workers' compensation, or insurance contract prohibits payment for these services I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third-party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances.

If the information provided to Marcotte Physical Therapy Inc, by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment of services. I understand that my good faith payment may not be inclusive of all payments for which I am responsible and I may be billed for any remaining balance. I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of Marcotte Physical Therapy Inc.

Initial_____

PATIENT OR GUARDIAN SIGNATURE_____ DATE_____