

## AUTHORIZATION FOR TREATMENT

I authorize the Healthcare Provider to administer treatment as deemed necessary or advisable in the diagnosis and treatment of any condition related to the patient consistent with, Advance Directive, Living Will or Durable Power of Attorney for Healthcare of file.

## ASSIGNMENT OF BENEFITS, PAYMENT TERMS AND RELEASE OF INFORMATION

As the Guarantor of this account, I agree to assign to Hands on Physical Therapy all insurance benefits otherwise payable to the patient or insured for services rendered. I agree to be held financially responsible for services rendered by Hands on Physical Therapy that are not covered by my insurance company. I understand that it is my responsibility to notify the provider of any changes in insurance coverage. I know that I will pay the balance owed if the insurance or personal information I have given is not true.

I authorize the release of pertinent medical records to the patient's insurance carrier for the purpose of claims payment. I understand that this applies to all types of insurance coverage, including but not limited to Medical, Worker's Compensation and Liability/Auto. I understand that the only records released would be pertinent to the date of service and to the carrier providing the coverage for that date of service. Failure to provide this authorization may result in the insurance carrier's denial of a claim. I have been given a copy of the practice's Financial Policy when applicable and understand its content.

I also have the right to request a copy of the Notice of Privacy Practices at anytime.

Signature: \_\_\_\_\_

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