AUTHORIZATION FOR TREATMENT

1. **AUTHORIZATION FOR TREATMENT:** I hereby authorize **ACCESS PT** to provide physical or occupational therapy treatment and services to myself or the named patient. I also authorize the release of such information that may be necessary for my care via mail, electronic or facsimile transmission.

2. **RELEASE AND ASSIGNMENT OF INSURANCE BENEFITS:** I hereby authorize **ACCESS PT** to bill my insurance company directly for the covered portion of charges, and I authorize payment of medical benefits directly to **ACCESS PT**. I authorize ACCESS PT to release medical or other information necessary to process this claim. I understand that I am ultimately responsible for my therapy charges, and I agree to pay my deductible, co-payment or co-insurance, and any charges not reimbursed by my insurance carrier. I understand that some insurance carriers require medical or administrative pre-authorization for treatment or have reimbursement limits on physical therapy treatment. I understand I am responsible for knowing and meeting the requirements of my insurance plan.

3. **DISCLOSURE OF HEALTH INFORMATION:** I understand that **ACCESS PT** is a health provider who must comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA protects the privacy of individually identifiable health information. The **ACCESS PT** Notice of Privacy Practice outlines your rights and our responsibilities regarding your medical information and who to contact if you have any concerns regarding your medical information. By signing below, I acknowledge that I have access to the **ACCESS PT** Notice of Privacy Practices through the website, patient portal or by requesting a copy.

4. **CANCELLATION AND NO SHOW POLICY:** With the exception of serious emergencies, it is expected that you keep all your appointments. If you need to re-schedule an appointment, we require 24 hours' notice. In such a case, please call our office and arrange for a make-up appointment with our Patient Coordinator. **In instances of repeated cancellations without 24 hours' notice or no-shows to a scheduled appointment, we reserve the right to charge you a $50 fee as allowed by insurance contracts.**

The undersigned certifies that he/she has read the foregoing and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute this document and accept and agree to its terms.

Patient Name (Printed): _____ **Date:** _____

Patient (or Representative) Signature: _____

Patient Representative Name (Printed): _____

CARD ON FILE AGREEMENT: By signing below, I authorize **ACCESS PT** to keep my signature & my credit card information securely on file in my account. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form. We never process payment without your permission. You may be sent a statement after your insurance(s) processes your claims. If the credit card that I give today changes, expires, or is denied for any reason, I agree to immediately give **ACCESS PT** a new, valid credit card which I will allow them to charge over the telephone. Even though **ACCESS PT** is not processing the new card in person, I agree that the new card may be used with the same authorization as the original card I presented.

Credit Card Holder Name (Printed): _____

Credit Card Holder Signature: _____

EMERGENCY CONTACT INFORMATION:

Emergency Contact: _____Relation: _____

Phone Number: _____Other Phone: _____