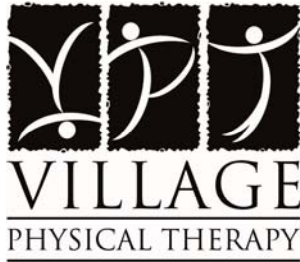

______________________________ ________________

Patient Name **Date of Birth**

Treatment Authorization / Medical Release

I allow Village Physical Therapy to provide my physical therapy treatment and services. I hereby give my permission to Village Physical Therapy to leave messages on the voicemail or to family members contacted with the home and/or cell numbers provided. Communications could be related to scheduling, billing, medical, and insurance. I also authorize the release of any medical information to/from the referring physician and others listed below:

Physician: ____________________________Phone #: ________________

Other: _______________________________Phone #: ________________

__________________________________ ____________

Signature of Patient / Responsible Party **Date**

Release and Assignment of Benefits

Village Physical Therapy may bill my insurance company or other entity designated by me directly for the covered portion of my charges. I authorize medical benefits to be paid directly to Village Physical Therapy. Ultimately, I am responsible for my physical therapy charges, and agree to pay my deductible, co-payment or co-insurance, and charges not covered by my insurance carrier. Some insurance companies require pre-authorization for treatment and have limits on physical therapy visits. I understand I am responsible for knowing and meeting the requirements of my insurance plan. I authorize Village Physical Therapy to release my medical records to my insurance company upon their request.

__________________________________ ____________

Signature of Patient / Responsible Party **Date**

Privacy Policy

The Privacy Practice Policy for Village Physical Therapy was made available to me. Included in the privacy policy is a release to allow my billing to be outsourced to Liberty Automated Medical Billing Services. Information shared will conform to HIPAA guidelines and will not be distributed to any unauthorized source.

_______________________________ __________

Signature of Patient / Responsible Party **Date**

____

Relationship to patient