Patient Authorization Record

Initial here _____	**Authorization for Treatment** ➢ I hereby give authorization for the performance of such rehabilitation procedures as permitted by Summit Physical Therapy, PLLC. Statutes under the appropriate scope of practice are, in the judgment of my therapist, deemed necessary.
Initial here _____	**Authorization for Release of Information** ➢ I agree that Summit Physical Therapy, PLLC may provide information from my medical record to persons involved in my medical care. ➢ I authorize the release of medical information necessary to obtain payment of any benefits available to me to Summit Physical Therapy, PLLC for services rendered. ➢ I agree that Summit Physical Therapy, PLLC obtain information from others who have provided medical care to me and/or are responsible for the payment of all or part of my bills when this information is needed in order to treat, bill, and/or receive payment. ➢ I have read "Notice of Privacy Practices" mandated by HIPAA.
Initial here _____	**Authorization for Release of Payment** ➢ I authorize that direct payment of any benefits available to me be released to Summit Physical Therapy, PLLC for services rendered.
Initial here _____	**Patient Agreement** ➢ I agree to pay Summit Physical Therapy charges for services rendered to me during my course of treatment. ➢ I agree to pay those charges which may not be paid by my health insurance and are my responsibility per my insurance benefit. If I do not pay for charges that are my responsibility, I agree to pay Summit Physical Therapy collections costs including attorney and court fees.
Initial here _____	**Cancellation/No Show Agreement** ➢ I understand that 24-hour advanced notice is required for appointments that I need to reschedule or am unable to attend. If 24-hour notice is not received, I understand a $50 fee will be billed to me and that this fee is due at the time of my next scheduled visit. I also understand that after 3 consecutive missed appointments I will discharged from care without notice.
Initial here _____	**Medicare, Medicaid, and Similar Benefits** ➢ I agree that the information given to Summit Physical Therapy, PLLC in applying for benefits under Medicare, Medicaid, and Maternal or Child Health services are complete and accurate. I agree that Summit Physical Therapy, PLLC may give Social Security Administration or its fiscal intermediary's information necessary to process claims.
Initial here _____	**Workers Compensation** ➢ I agree that the information given to Summit Physical Therapy, PLLC in applying for benefits under Workers Compensation is complete and accurate. I agree that Summit Physical Therapy, PLLC may give intermediary's information necessary to process claims.

_____

Print patient name

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Patient signature (Parent/Guardian if patient under 18) Date