Authorization to Release/Receive Medical Information & Assignment of Benefits

We feel strongly that all patients deserve the very best medical care we can provide. Further, we feel that everyone benefits when definitive financial arrangements are agreed upon. Accordingly, we have prepared this material to acquaint you with our policy. Our professional services are rendered to you, not the insurance company. Therefore, payment is your responsibility.

PLEASE READ & INITAL THE FOLLOWING:

___ I authorize this office to release or receive any information necessary to expedite insurance claims.

___ I authorize this office to bill my insurance company directly for their services.

___ I authorize payment directly to this provider of my insurance benefits otherwise payable to me.

___ In the event I receive payment from my insurance carrier, I agree to endorse any payment over to the provider for which these fees are payable.

___ I hereby authorize Active Edge physical therapist(s) to release information regarding services rendered by them and allow a photocopy of my signature to be used to file insurance. I hereby authorize Active Edge Physical Therapy to perform any service (evaluation, treatment procedures and testing) necessary for my rehabilitation.

___ Active Edge Physical Therapy is granted permission to release to the insurance carrier, employer, attorney, their representatives, or referring physician any information in connection with any treatment rendered to patient or on patient's behalf at any time such information is requested.

___ HIPAA: I have received the clinic's "Notice of Privacy Practices" and understand that my health information may be used by the clinic as described in the notice.

___ I understand that I am directly and completely responsible to this provider for charges not covered by my insurance. I further understand that such payment is contingent on any settlement, judgment or insurance payment by which I eventually recover said fee.

Acknowledgement of Notice of Privacy Practice

I understand that Active Edge Physical Therapy (referred to below as “the Clinic”) will use and disclose **health information** about me in the course of providing physical therapy care to me.

I understand that my **health information** may include information both created and received by the clinic, may be in the form or written or electronic records or spoken words, any may include information about my health history, status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar health related information.

- I understand that the clinic is permitted to **use and disclose** my health information in order to:
- Make decisions about and plan for my care and treatment.
- Refer to/or consult and coordinate with other health care providers in the course of my treatment.
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or other who may be responsible to pay for some or all of my healthcare
- Perform various office, administrative, and business functions that support the clinic’s ability to provide me with appropriate care and arrange for payment.

A Photostat copy of these authorizations and agreements shall be as valid as the original.

By signing below, I agree that I have received or been offered a copy of this clinic’s Notice of Privacy Practices & Assignment of Benefits.

______________________________ ________________________________ _______________

Patient or Guardian (print) Patient or Guardian (signature) Date