PATIENT AUTHORIZATIONS

Consent to Treat

The patient has the right to informed participation in decisions involving his/her health care. This shall be based on clear, concise explanation of his/her condition and of all proposed treatment procedures. All possible risks and/or side effects, as well as the probability of success with such procedures shall be disclosed to the patient by his/her attending physical therapist. The patient shall not be subjected to any procedure without his/her voluntary, competent and understanding consent or consent of his/her legally authorized representative. Where medically significant alternatives for care or treatment exist, the patient shall be so informed.

I have read and understand this and consent to receive physical therapy treatment at Elite Therapy & Fitness.

Initial _____

Authorization to Release/Receive Information

I give my consent to Elite Therapy & Fitness to disclose health information to my insurance carrier for the purpose of billing, to my physician or other healthcare professionals involved in my care, or receive health information from other healthcare professionals as it relates to my treatment, as permitted/required by law. I understand that confidentiality of my health information is protected under state and federal law, and that this release gives consent to Elite Therapy & Fitness, only, and not to any party to whom such information is released. (Please refer to the Privacy Notice for a more complete description of such uses and disclosures. You have the right to review the notice prior to signing this consent.)

Initial _____

Patient Payment Policy

The fee schedule of Elite Therapy & Fitness is based on usual and customary fees for the type of services provided. Generally, your insurance policy will cover some portion, if not all, of the payment for services provided. **There is, however, no guarantee of payment**. **The balance amount, if any, that your insurance carrier does not cover will be your responsibility. You are also responsible for any deductible and co-pay. **PLEASE NOTE, IF YOU HAVE A COPAY WITH YOUR PRIMARY INSURANCE, AND YOU HAVE A SECONDARY INSURANCE, WE WILL AS A COURTESY TO YOU SUBMIT THIS TO YOUR SECONDARY INSURANCE A MAXIMUM OF TWO TIMES. IF NO PAYMENT IS RECEIVED OR YOUR SECONDARY INSURANCE DOES NOT RESPOND, YOU WILL BE BILLED AND EXPECTED TO PAY THE BALANCE, AT WHICH TIME YOU WILL BE GIVEN A "PAID" RECEIPT THAT YOU WILL THEN BE ABLE TO SUBMIT TO YOUR SECONDARY INSURANCE FOR REIMBURSEMENT.**

We request that any insurance payments that are sent directly to you be presented promptly to Elite Therapy & Fitness, along with the explanation of benefits and/or any other information you received with the payment. You are directly responsible for payment of medical supplies. Monthly statements will be sent to you if you have an outstanding patient balance. Payment for your portion of services, as outlined in the statement under the "Due From Patient" column is requested to be paid within fifteen (15) days of receipt of the statement.

I understand that I am responsible to pay any balance due that insurance does not cover with 60 days of final billing.

Initial _____

Medicare Patients Only

I request that payment of authorized Medicare benefits be made to me or on my behalf to the practitioner named above. I authorize any holder of medical information about me to release to the Health Care Financing administration and its agents any information needed to determine benefits or the benefits payable for related services. I have read this information and understand its content.

Initial _____

HIPAA Privacy Policy

I have been offered a copy of the Notice of Privacy Practices.

Initial _____

Patient Signature: _____ Date: _____