



Patient Authorization

Patient Name: _____ Date of Birth: _____ Age _____

Release of Information & Consent for Treatment

All information provided herein is true and correct.

I am aware of my diagnosis and wish to receive treatment at Arizona Multisports Physical Therapy. I permit its employees and all other persons caring for me to treat me in ways they judge beneficial to me. I understand that this care can include evaluation, testing and treatment. No guarantees have been made to me about the outcome of this care.

I give permission to Arizona Multisports Physical Therapy to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it related to my treatment or payment for services provided.

I authorize Arizona Multisports Physical Therapy to obtain medical records and/or professional information from my physicians or other medical professional as it related to my treatment.

The signature below certifies that I have read and understand the above information. Initial: _____

Assignment of Benefits

I authorize payment directly to Arizona Multisports Physical Therapy and/or its affiliates for services and to bill and release payment to Arizona Multisports Physical Therapy and/or its affiliates.

This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original.

Initial _____

Notice of Privacy Practices (HIPPA Acknowledgement/Consent)

I hereby acknowledge that I have reviewed a copy of The Notice of Privacy Practices for Arizona Multisports Physical Therapy, its subsidiaries, and/or affiliates.

In addition, I hereby consent to the use and disclosures of my personal health information for the purposed of treatment, payment, and health care operations.

Initial _____



Payment Guide

I agree to pay Arizona Multisports Physical Therapy for the services provided to me or the party named above. If any law, such as workers' compensation, or insurance contract prohibits payment for these services I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third-party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances.

The benefit Verification is only an explanation of coverage obtained from my insurance company and it is not a guarantee of coverage. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment of services.

I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of Arizona Multisports Physical Therapy.

Initial _____

Patient or Guardian Signature: _____ Date: _____