



**ARIZONA MULTISPORTS  
PHYSICAL THERAPY LLC**

*Wellness with Motion  
Since 2009*

**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 information above. 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 \_\_\_\_\_