**AUTHORIZATION TO TREAT/FINANCIAL POLICY**

**\*\* PLEASE INITIAL THE FOLLOWING:**

**\_\_\_\_ I HEREBY AUTHORIZE COMPLETE PT TO PROVIDED TREATMENT AS PRESCRIBED BY MY PHYSICIAN AND CONSENT TO EVALUATION AND TREATMENT PROCEDURES WHICH MY BE DEEMED ADVISABLE BY MY PHYSICIAN FOR MEDICAL CARE PROVIDED BY COMPLETE PT. I UNDERSTAND A VARIETY OF TREATMENT OPTIONS AND TECHNIQUES MAY BE USED. I UNDERSTAND THAT NO ASSURANCE CAN BE GIVEN THAT THE COURSE OF TREATMENT WILL IMPROVE MY CONDITION.**

**\_\_\_\_ I HEARBY ASSIGN ALL INSURANCE BENEFITS FOR SERVICES RENDERED TO WHICH I AM ENTITLED TO BE PAID DIRECTLY TO COMPLETE PT. I UNDERSTAND THAT IF MY INSURANCE COMPANY/THIRD PARTY PAYER DENIES PAYMENT OR MAKES PARTIAL PAYMENT, I AM RESPONSBILE FOR THE BALANCE DUE.**

**\_\_\_I HEREBY AUTHORIZE THE RELEASE OF MEIDCAL RECORDS TO COMPLETE PT AND ANY PERTINENT INFORMATION CONCERNING THE PATIENT FOR THE PROVISION OF CARE AND FOR OBTAINING INSURANCE REIMBURSEMENT.**

**\_\_\_ I UNDERSTAND THAT AS A COURTESY, COMPLETE PT WILL VERIFY MY COVERAGE BUT THAT I AM LEGALLY RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED BY COMPLETE PT. IF MY INSURANCE IS BEING BILLED, I WILL BE RESPONSIBLE FOR PAYING ANY DEDUCTIBLE AMOUNTS. I UNDERSTAND THAT CO-PAYMENTS ARE DUE AT TIME OF SERVICES. (THIS DOES NOT APPLY OT WORKER’S COMPENSATION PATIENTS)**

**SIGNATURE OF PATIENT/GUARDIAN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_**

**ACKNOWLEDGEMENT OF RECEIPT**

**1. I have received a copy of this offices’s Notice of Privacy Practices Y / N Initial\_\_\_\_\_**

**2. I agree that PT/PTA students may participate in my physical therapy care. Y / N Initial \_\_\_\_**

**As a courtesy, we will gladly bill your insurance company for you. However, you are responsible for the total balance due. Ultimately, it is your responsibility to check your insurance benefits regarding deductibles and copays. Any disputed claims are between you and your insurance company. We will be happy to provide your insurance company with any information that is needed to process your claim(s).**