

You must be 18 years or older in order to sign the following authorizations

AUTHORIZATION TO TREAT:

I hereby authorize Sports Medicine Inc., d/b/a Orthopedic Physical Therapy, to evaluate and treat me/my minor child with those modalities and procedures recommended by my/his/her physician and physical therapist. I also understand that my treatment may include the use of equipment and facilities at The Body Shoppe Health and Fitness Center and consent to allow continued treatment in that environment.

PHONE MESSAGES:

O.P.T. customarily calls to confirm initial evaluations and 10 day rechecks. A physical therapist may call if you have missed an appointment or to inquire of your status if you have not been in for some time. The O.P.T. billing office may call with questions or concerns regarding the billing of your account. If you are not home, is it OK to leave a message on your answering machine?

YES NO Other: _____

OBLIGATION TO OBTAIN REFERRAL:

I understand that I have an obligation to obtain any necessary referrals required under the terms of my insurance coverage for physical therapy services. If the proper authorization or referral is not obtained, I understand that I am financially responsible for any charges consequently denied.

OBLIGATION TO NOTIFY US OF PRIOR TREATMENT:

My insurance may have limitations that are effected by prior physical therapy treatment received for my current diagnosis or in this calendar year. If I do not disclose information to O.P.T. of prior services, I understand that I am financially responsible for any charges consequently denied.

I have had other physical therapy services NO YES - Where: _____

AUTHORIZATION TO PAY BENEFITS:

I hereby authorize my insurance carrier to make payment directly to Sports Medicine Inc. d/b/a Orthopedic Physical Therapy for all services rendered.

OBLIGATION TO PAY:

I understand that I am financially responsible for any charges not covered by my insurance, as well as any deductibles or copayments required by my insurance plan.

PRIVACY POLICY:

I have received a copy of Sports Medicine Inc. d/b/a Orthopedic Physical Therapy's Notice of Privacy Practices and Individual Rights.

I HAVE READ AND AGREE TO THE ABOVE:

print patient name

signature of patient (or parent if a minor child)

date
rev 12/09