Assignment of Benefits Form / HIPAA / Financial Responsibility

Financial Responsibility

I have requested medical services from Affiliated Physical Therapy on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Assignment of Benefits

I hereby authorize and direct my insurance carrier(s), private insurance and any other health/medical plan, to **Issue payment check(s) directly to Affiliated Physical Therapy** for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize **Affiliated Physical Therapy** to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

Medical Authorization for Release / Disclosure of Protected Health Information / HIPAA Privacy Notice has been provided.

This is to authorize you to release any information regarding my condition and care to My Insurance Carrier(s), or Other Health Care Providers or Referring Physicians directly associated with my care. I "do" authorize Affiliated Physical Therapy and staff to provide and/or discuss my care and medical needs with my immediate family; spouse; children; parents.

X _____ Date: _____

Patient / Responsible Party Signature

_____ Date: _____

Witness

COMPLETE THIS SECTION ONLY IF YOU "DO NOT" WANT INFORMATION DISCUSSED OR RELEASED TO SPECIFIC INDIVIDUALS

I "DO NOT" authorize Affiliated Physical Therapy to provide and/or discuss my care and medical needs with:

(1)_____ (2) _____ (3) _____

X_____ Date: _____

Patient/Responsible Party Signature

_____ Date: _____

Witness