TEAM™ PHYSICAL THERAPY P.C.

Together Empowering Able Movement

AUTHORIZATION AND CONSENT FOR TREATMENT

PATIENT'S NAME: _____ TODAY'S DATE: _____

Date of Accident/Injury _____ Work related injury Yes / No

Motor vehicle accident: Yes / No Liability Claim Yes / No

If you answered Yes to any of the above please complete Work Comp/Liability Authorization.

Please read, complete and initial each of the following:

_____/ I hereby authorize TEAM Physical Therapy, P.C. staff to administer all outpatient physical therapy treatments and procedures as deemed medically necessary.

_____/ I hereby authorize TEAM Physical Therapy, P.C. to provide copies of my physical therapy notes as requested by my insurance/assurance company, attorney or any other outside source representing me. I authorize the release of any information including the diagnosis and the records of any treatment/examination rendered to me (or my dependent) during the period of such care to third party payers and/or other health care practitioners. I understand that I am responsible for the cost of postage/copying fees for these documents. I agree to payment of these fees in the event that the representing party's policy prevents them from paying for this service. I understand that a separate HIPPA authorization release may be needed from me for each party requesting documentation.

_____/ Including myself, the following person(s) or organization(s) are authorized to receive my health information

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

I understand I may revoke this at any time by written notification.

_____/ In the event of an emergency I request TEAM Physical Therapy, P.C. contact the following:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

_____/ I have been offered a copy of TEAM Physical Therapy, P.C. Notice of Privacy Practices containing a complete description of the use and disclosure of my health information. I understand that this business has the right to change the Notice of Privacy Practice and I may contact TEAM Physical Therapy, P.C. at any time to request a current updated copy of the Notice of Privacy Practices

_____/ I have been offered a copy of TEAM Physical Therapy, P.C. Bill of Rights & Responsibilities containing an overview of my responsibilities and rights pertaining to my, or my dependents, physical therapy treatment(s). I understand that this business has the right to change the Bill of Rights & Responsibilities and I may contact TEAM Physical Therapy, P.C. at any time to request a current updated copy of the Bill of Rights & Responsibilities.

_____/ I have a Supplemental Assurance Plan (AFLAC, Colonial Life, Broker's National, Student Assurance Etc.) and upon discharge from care would like a full statement of my case sent to the following agent. I consent to allow TEAM Physical Therapy, P.C. staff to discuss my treatment and billing statement with my agent to answer any questions or release copies of my notes as they pertain to this case only.

Assurance Company: _____ Agent's Name: _____

Agent's City/State: _____ Agent's Phone Number: _____

The undersigned has read and completed all the above information accurately.

Signed: _____ OR_____

Patient (must be 19) Authorized person / relationship to patient

Date _____ Time: _____A.M. / P.M. Witness: _____