SHIPE
PHYSICAL THERAPY
YOUR COMEBACK IS ALWAYS GREATER THAN THE SETBACK

Patient Authorization

I authorize Shipe Physical Therapy to bill my insurance company directly for the covered portion of charges, and I authorize payment of medical benefits directly to Shipe Physical Therapy. I authorize Shipe Physical Therapy to release medical or other information necessary to process this claim. I understand that I am ultimately responsible for my physical therapy charges and I agree to pay my deductible, my co-insurance or co-payment, and any charges NOT reimbursed by my insurance carrier. I understand that some insurance companies require medical or administrative pre-authorization for treatment, or have reimbursement limits on physical therapy treatment. I understand I am responsible for knowing and meeting the requirements of my insurance plan.

Consent for Treatment and Release of Information
All information provided herein is true and correct.

I am aware of my diagnosis and wish to receive treatment at Shipe Physical Therapy. I permit its employees and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care can include an evaluation, testing, and treatment. No guarantees have been made to me about the outcome of this care.

I hereby consent to use and disclosure of my personal health 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 persons as it relates to my treatment. In addition, I authorize Shipe Physical Therapy to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.

Assignment of Benefits
I authorize payment directly to Shipe Physical Therapy. This is a direct assignment of my rights and benefits under this policy.

Notice of Privacy Policy
I hereby acknowledge that I have been offered a copy of the privacy practice notice for Shipe Physical Therapy.

I have read the above terms and agree with them. I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of treatment unless agreed to in writing by myself and a representative of Shipe Physical Therapy.

The signature below certifies that I have read and understand the above information.

Patient Name_____Signature_____Date_____