ORTHOBALANCE PHYSICAL THERAPY

Attilio S. Pensavalle, PT DPT
Doctor of Physical Therapy
287 Northern Boulevard, Suite 104
Great Neck, New York 11021
Tel: 1-516-482-0100 Fax: 1-516-482-0172

INFORMED CONSENT & AUTHORIZATIONS [HIPAA]

PATIENT NAME:___________________________________

CONSENT FOR TREATMENT:

I hereby give my permission for ***OrthoBalance Physical Therapy*** to render treatment to me/my dependent. I understand that I will be given all available pertinent information prior to the treatment being rendered. I will be given the opportunity to ask questions and to have them answered to my satisfaction. I understand that I may decline treatment at any time

______________________________ __________

SIGNATURE *DATE*

CONSENT TO RELEASE/OBTAIN MEDICAL INFORMATION:

Permission is hereby granted to ***OrthoBalance Physical Therapy*** to release information to my insurance company, employer, attorney, workers compensation carrier, physician/facility referred to for further treatment and/or my referring/family physician. Permission is hereby granted to any medical or healthcare facility where I have previously been treated to release medical records to ***OrthoBalance Physical Therapy.***

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SIGNATURE *DATE*

AUTHORIZATION FOR DISCLOSURE of PHI TO ADDITIONAL PERSONS [family, etc.]:

In addition to the authorization for release of my PHI described in the above section of this Authorization, I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):

Name ____ *Relationship* _____________________

Name ____ *Relationship* _____________________

______________________________ __________

SIGNATURE *DATE*

AUTHORIZATION FOR PAYMENT & ASSIGNMENT OF BENEFITS:

I authorize ***OrthoBalance Physical Therapy*** to bill my health insurance for services rendered. All payments received will be applied to my balance. **I will be responsible for all co-pays/co-insurance and deductibles that may apply.** Although ***OrthoBalance Physical Therapy*** will help verify and assist me in understanding my benefits, it is ultimately my responsibility and I will not hold ***OrthoBalance Physical Therapy*** responsible for any misinterpretation of insurance benefits. I understand that any charges not paid by my insurance company are my responsibility, and are due and payable by me.

______________________________ __________

SIGNATURE *DATE*

MEDICARE PATIENTS ONLY:

I authorize payment of Medicare benefits to ***OrthoBalance Physical Therapy*** for services rendered, and I authorize the release of medical information to CMS (Centers for Medicare and Medicaid Services) and/or its agents.

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SIGNATURE *DATE*