

**PERMISSION FOR CARE**

I give my permission for Physical Therapy, etc. to provide care or equipment to me (or to a person for whom I am legally responsible) in accordance with my doctor's referral and/or generally accepted practice.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**CONSENT FOR USE OF PERSONAL INFORMATION**

This Consent for the use and/or disclosure of personally identifiable health information is made pursuant to the requirements of 45 C.F.R. § 164.506, which sets out the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996.

I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by PHYSICAL THERAPY, etc. for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the regulations.

This Consent for the use and/or disclosure of the specific personally identifiable health information set forth in the Authorization is made pursuant to the requirements of 45 C.F.R. § 164.508, which sets out the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996.

I, the undersigned, authorize the use and/or disclosure of personally identifiable health information about me as described below:

1. I authorize the following person(s) or class of persons to use and/or disclose the information:  
 Employees of Physical Therapy, etc       Other \_\_\_\_\_
2. I authorize the following person(s) or class of persons to receive the information:  
 Spouse \_\_\_\_\_  Child \_\_\_\_\_  
 Attorney \_\_\_\_\_  Other \_\_\_\_\_

I am aware that Physical Therapy, etc. maintains a Privacy Notice which sets forth the types of uses and disclosures that PHYSICAL THERAPY, etc. is permitted to make under the regulations and sets forth in detail the way in which PHYSICAL THERAPY, etc. will make such use or disclosure. By signing this Consent, I understand and acknowledge that I have the right to review the Privacy Notice prior to signing this Consent.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**FINANCIAL OBLIGATION**

**YOU ARE FINANCIALLY RESPONSIBLE FOR ALL SERVICES PROVIDED TO YOU.**

I authorize Physical Therapy, etc. to bill my primary and or secondary insurance and that I request payment be made on my behalf to Physical Therapy, etc.

1. I understand that amounts of less than \$2.00 are not billed or refunded.
2. I have the primary responsibility to understand the limitations of my insurance coverage and to monitor the use of my benefits.
3. If this is a Workers' Compensation case necessary information may be given to the applicable employer.
4. Unless laws or a contract with my insurance company states otherwise, I acknowledge that I am responsible for **ALL** charges. This includes deductibles, co-pays, coinsurance, non-covered services or services in excess of limits set by my insurance company.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_