PRESTIGE
PHYSICAL THERAPY, LLC

AUTHORIZATION AND GUARANTEE

Patient: _____ DOB: _____

Please read and initial each statement.

_____ Insurance Benefits (if applicable): The benefit information obtained cannot be considered a guarantee of actual benefits or insurance payment for services rendered. You are encouraged to contact your insurance company to verify your benefit information, including any copays/coinsurance, deductibles, etc. that may apply. Any questions that you have regarding your insurance should also be directed to your insurance company. Their contact information can be found on the back of your insurance card.

_____ Medicare (if applicable): I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries any such information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I understand that I am responsible for any health insurance deductibles or coinsurance.

_____ Guarantee of Payment (not applicable for Worker's Compensation patients): In consideration of services rendered to me by Prestige Physical Therapy, I hereby guarantee payment of any and all services not covered or allowed by insurance. I also understand that all bills are due and payable upon receipt. I understand that the patient responsibility portion of my bill will be due and payable at the time of service. I understand that should my account with Prestige be delinquent and turned over to a collection agency, that I, the undersigned, will be responsible to pay all collection agency fees, court costs or any other fees/costs associated with resolving my account balance including reasonable attorney's fees.

_____ Returned Checks: We are happy to accept your personal check for payment. However, if your check is returned for any reason, you expressly authorize your account to be electronically debited or bank drafted for the amount of the check plus any applicable fees. The use of a check for payment is your acknowledgement and acceptance of this policy and its terms and conditions.

_____ Consent for Treatment: I hereby consent to such treatment procedures and patient care which, in the judgement of my therapist and/or physician, may be considered necessary or advisable while a patient at Prestige Physical Therapy.

_____Waiver and Release: I hereby release, discharge, and acquit Prestige Physical Therapy, it's agents, representatives, affiliates, employees or assigns of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from any refusal to accept, receive or allow emergency and/or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services.

_____Authorization to Release Medical Information: I consent to allow Prestige Physical Therapy, to use and disclose my protected health information (PHI) within Prestige Physical Therapy to carry out my treatment, to obtain payment and to carry out health care operations. My PHI may be disclosed to my health plan and/or its agents as necessary to verify benefits, authorize services and process medical claims. My PHI may be disclosed to outside health agencies or institutions involved in continuing care and/or for emergency care purposes. My PHI may include medical information or any information pertaining to the evaluation, treatment and history. This may include psychiatric, HIV/AIDS, sickle cell, alcohol and/or drug information, coded medical information and charges to my health plan and/or their intermediaries. This consent is subject to revocation at any time except to the extent that action has been taken in reliance on it. Withdrawal of consent shall be addressed in writing.

_____Assignment of Benefits: I authorize my health plan to pay benefits directly to Prestige Physical Therapy. I understand that in the event my health plan or healthcare contract does not cover services. I will be responsible for payment. I understand that if my health plan does not consider Prestige Physical Therapy a participating provider, charges incurred will be paid by me. Furthermore, I understand that I can request and receive a copy of the document.

_____HIPPA: Notice of Privacy Practices are available upon request. PHI may be disclosed or used for treatment, payment or healthcare operations. The patient has the right to restrict the use of their information. The patient may revoke this consent in writing at any time and future disclosures will cease.

I CERTIFY THAT I HAVE RECEIVED A COPY OF THIS FORM, UNDERSTAND ITS CONTENTS AND ACCEPT ITS TERMS.

_____ _____

Signature of Patient/Legal Representative Date