



Patient Name: _____

Authorization for Treatment

I hereby authorize Montgomery Physical Therapy & Wellness to provide physical therapy treatment and services to myself or above named patient. I also authorize the release of such information that may be necessary for my care via mail, electronic or facsimile transmission.

Release and Assignment of Benefits

I hereby authorize Montgomery Physical Therapy & Wellness (MPTW) to bill my insurance company directly for the covered portion of charges, and I authorize payment of medical benefits directly to MPTW. I authorize MPTW 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, co-payment or co-insurance, and any charges not reimbursed by my insurance carrier. I understand that some insurance carriers 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.

Signature of Patient or Responsible Party

Date

Acknowledgment of Receipt of Notice of Privacy Practices

Montgomery Physical Therapy & Wellness reserves the right to modify the privacy practices outlined in the notice.

Signature

A copy of the Notice of Privacy Practices for Montgomery Physical Therapy & Wellness was given or made available to me.

Signature of Patient

Date

Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form.)

Relationship of Patient Representative to Patient