Authorization, Billing, and Release of Information

I hereby give authorization for the performance of such rehabilitation procedures as permitted by **Elite Spine & Extremity Physical Therapy** Statutes under the appropriate scope of practice are, in the judgment of my Therapist, deemed necessary. I authorize Elite Spine & Extremity Physical Therapy to bill my insurance company directly and payment of such is to them. I understand that I am ultimately responsible for any accrued charges, including my copay, co-insurance, deducible, or any charges not reimbursed by my insurance company.

I agree that **Elite Spine & Extremity Physical Therapy** may provide information from my medical record to persons involved in my medical care, *including the referring provider*.I authorize the release of medical information necessary to obtain payment of any benefits available to me to Elite Spine & Extremity Physical Therapy for services rendered.I agree that **Elite Spine & Extremity Physical Therapy** may obtain information from others who have provided medical care to me and/or are responsible for the payment of all or part of my bills when this information is needed in order to treat, bill, and/or receive payment.I have read "Notice of Privacy Practices" mandated by HIPAA.

I allow Elite Spine & Extremity Physical Therapy to release my information to the following:

1.____

2.____

3.____

4.____

Medicare, Medicaid, and Similar Benefits

I agree that the information given to **Elite Spine & Extremity Physical Therapy** in applying for benefits under Medicare, Medicaid, and Maternal or Child Health services are complete and accurate. I agree that **Elite Spine & Extremity Physical Therapy** may give Social Security Administration or its fiscal intermediary's information necessary to process claims.

Workers Compensation/ No Fault

I agree that the information given to **Elite Spine & Extremity Physical Therapy** applying for benefits under Workers Compensation No Fault is complete and accurate. I agree that **Elite Spine & Extremity Physical Therapy** give intermediary's information necessary to process claims.

Appointment Policy

All missed appointments besides being unable to be scheduled within same week or not due to health/family emergencies will be charged a fee of $25.00.

I agree and understand that I am to make all my scheduled appointments, and If I cannot attend, I understand that I am required to give **Elite Spine & Extremity Physical Therapy** 24 hours notice if possible, or rescheduling within the same week. Situations outside of my control will be taken into consideration by their management staff. Auth

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Patient signature Date