Patient Authorization Record

Authorization for Treatment

- I hereby give authorization for the performance of such rehabilitation procedures as permitted by Nebraska Statutes under the appropriate scope of practice are, in the judgment of my Therapist, deemed necessary.

Authorization for Release of Information

- I agree that Pearson Physical Therapy, PC may provide information from my medical record to persons involved in my medical care.
- I authorize the release of medical information necessary to obtain payment of any benefits available to me to Pearson Physical Therapy, PC for services rendered.
- I agree that Pearson Physical Therapy, PC 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 agree the Pearson PT may obtain information/records from _____ regarding my _____.
- I have read "Notice of Privacy Practices" mandated by HIPAA.

Authorization for Release of Payment

- I authorize that direct payment of any benefits available to me be released to Pearson Physical Therapy, PC for services rendered.

Patient Agreement

- I agree to pay Pearson Physical Therapy, PC charges for services rendered to me during my course of treatment, **including supplies not covered by insurance**.
- I agree to pay those charges which may not be paid by my health insurance and are my responsibility per my insurance benefit. If I do not pay for charges that are my responsibility, I agree to pay Pearson Physical Therapy, PC collections costs including attorney and court fees.

Medicare, Medicaid, and Similar Benefits

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

Workers Compensation

- I agree that the information given to Pearson Physical Therapy, PC in applying for benefits under Workers Compensation is complete and accurate. I agree that Pearson Physical Therapy, PC may give intermediary's information necessary to process claims.

No Show Policy

- I agree that if I do not notify Pearson Physical Therapy that I am unable to keep my scheduled appointment that I will pay $35 for each missed appointment. I also understand that insurance does not cover this fee.

List person(s) to whom medical/financial information can be released:

_____

Patient signature Date

_____

Printed patient name Witness Signature Date

_____

Signature of Legal Representative/POA