AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the release of my medical records to my health insurance plan as needed to determine insurance benefits support adjudication and payment of my health insurance claim. A copy of this authorization will be sent to my insurance carrier, or other medical entity, if requested. **Initial** _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been given the Notice of Privacy Practices for Troxell Physical Therapy. I recognize that outside of purposes for treatment, for payment, for certain health care operations or as permitted or required by law I must give my written authorization to Troxell Physical Therapy to release any of my protected healthcare information.

Patient / Parent or Authorized Representative Signature: _____

HIPPA-144 PN

ASSIGNMENT OF INSURANCE BENEFITS

I authorize that the payment of my insurance benefits be made directly to Troxell Physical Therapy for any services that are reimbursable by Medicare, Medicaid or any third-party payors and for any services related to my work injury / accident/ illness claim if Workers' Compensation. I will immediately advise the facility of any change to my insurance coverage or claim status. **Initial** _____

GUARANTEE OF PAYMENT

Co-pays, co-insurance or deductible must be paid at the time service is rendered (we accept cash and most major credit cards). **Initial** _____

I understand that insurance billing is provided as a courtesy and that I assume financial responsibility for any charges not covered by my insurance plan. Although Troxell Physical Therapy has verified benefits directly with my insurance plan, exact benefit coverage cannot be determined until the insurance plan receives the claim. **Initial** _____

I understand that all payments designated as the "patient's responsibility" including but not limited to non-covered services, services billed by the facility but paid directly to me, services billed to a Worker's Compensation payor subsequently declared by my employer as a non-eligible claim and all amounts due for claims submitted to my insurance company and not paid for 60 days will be billed to me and are due upon receipt. **Initial** _____

MEDICARE and WORKER'S COMPENSATION INFORMATION

I certify that the information I have provided to Troxell Physical Therapy for payment under the Social Security Act (Medicare) or under the Worker's Compensation Program is correct, including but not limited to any related accidents/ illness or other insurers/payors available. **Initial** _____

I, _____, understand the statements I have initialed above and declare their truthfulness.
(Patient printed name)

Patient /or Parent: _____ **Date:** _____
Signature