



Patient Authorization/Consent Record

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| | <p><u>Authorization for Treatment</u></p> <p>* I hereby give authorization for the performance of such rehabilitation procedures as permitted by Wisconsin Statutes under the appropriate scope of practice which are, in the judgment of my licensed Therapist, deemed necessary.</p> |
| | <p><u>Authorization for Release of Information</u></p> <p>* I agree that PT Plus may provide information from my medical record to persons involved in my medical care.</p> <p>* I authorize the release of medical information necessary to obtain payment of any benefits available to me to PT Plus for services rendered.</p> <p>* I agree that PT Plus 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</p> <p>* I acknowledge the receipt of "Notice of Privacy Practices" mandated by HIPPA.</p> |
| | <p><u>Authorization for the Release of Payment</u></p> <p>* I authorize that direct payment of any benefits available to me be released to PT Plus for services rendered.</p> |
| | <p><u>Patient Agreement</u></p> <p>* I agree to pay PT Plus charges for services rendered to me during my course of treatment.</p> <p>* I agree to pay those charges which may not be paid by my health insurance and are my responsibility. I agree to pay PT Plus collections, costs including attorney and court fees.</p> |
| | <p><u>Medicare, Medicaid, and Similar Benefits</u></p> <p>* I agree that the information given to PT Plus in applying for benefits under Medicare, Medicaid, and Maternal or Child Health services are complete and accurate. I agree that PT Plus may give Social Security Administration or its fiscal intermediary's information necessary to process claims.</p> |
| | <p><u>Workers Compensation</u></p> <p>* I agree that the information given to PT Plus in applying for benefits under Workers Compensation is complete and accurate. I agree that PT Plus may give intermediary's information necessary to process claims.</p> |
| | <p><u>Patient Rights</u></p> <p>* I understand that it is my right to be informed of my Therapist's findings, and his/her plan of care. I am an active participant in my health care and have the right to question/and or refuse treatment at my discretion.</p> <p>* I acknowledge that medicine is not an exact science, and no guarantees or warranties can be made to me regarding the results of any treatment at PT Plus.</p> |

I HAVE READ AND FULLY UNDERSTAND THE ABOVE AUTHORIZATIONS/CONSENTS.
ANY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION.

Patient Signature
Date

Printed Patient Name

Legal Representative/POA Signature
Date

