

Patient's Authorization to Disclose Medical Records

I, _____, authorize **Southside Physical Therapy, Inc.** to release medical
(Patient's Name)
information to be used on my behalf to the following:

Referring Physician=s Name	Your Insurance Company	Other
Other Physician	Other Insurance	

Please **initial** the following to authorize:

- _____ I consent to treatment by a physical or occupational therapist.
- _____ I specifically authorize the release of physical therapy records, occupational therapy records and any physician=s orders for therapy, to the parties mentioned above.
- _____ I authorize Southside Physical Therapy, Inc. to bill my insurance company and furnish information to them concerning my treatments.
- _____ I assign to Southside Physical Therapy all payments for services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.
- _____ I understand that I will be billed \$25.00 for any appointments canceled with less that 24 hours notice.
- _____ I have received or been offered a copy of this office's **Notice of Privacy Practices (HIPPA)**.

May we leave the following information on your answering machine at home or work? **(Please Initial)**

Appointment/schedule confirmations with date and time? Yes _____ No _____
Financial Information? Yes _____ No _____

CREDIT AGREEMENT

I, the undersigned, acknowledge responsibility for charges to the above account and promise to pay same within the payment and credit policies set by Southside Physical Therapy. Late payment past 30 days will be subject to a 1.5% interest charge, 18% annually, added monthly to the past due balance.

If my account is placed in the hand of an attorney for collection or turned over to any agency for collection, I/we agree to pay all reasonable collection costs and/or attorney fees even if no suit or action is filed thereon.

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire one year from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

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Signature of Patient	Date	(Parent or Guardian if applicable)	Date
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