THE PT PEOPLE
PHYSICAL, OCCUPATIONAL & SPEECH THERAPY

3300 South Street, Ste. 203 | Lakewood, CA 90805
Office: (562) 512-3320 | Fax: (562) 3817763

Patient Authorization & Guarantee Form

Release of Information
I hereby authorize the release of any information by telephone or in writing, including reports of diagnosis, treatment prognosis, recommendation, benefits payable, as well as any other data pertinent to my treatment, by Functional Rehabilitation Physical Therapy to the physician who referred me for therapy as well as any organization responsible for payment of my account. I also authorize the release of any information by telephone or in writing for utilization and quality review purposes.

Assignment of Insurance Benefits
I hereby authorize that the payment of authorized benefits is made directly to Functional Rehabilitation Physical Therapy for any services reimbursable by Medicare, Medicaid, or any third-party source.

Valuables
I hereby understand that Functional Rehabilitation Physical Therapy is not responsible for valuables and personal property brought to the facility.

Consent for Treatment
I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while I am a patient of Functional Rehabilitation Physical Therapy.

Guarantee of Account
In consideration of services rendered to me by Functional Rehabilitation Physical Therapy, I hereby guarantee payment for any and all services rendered to me which are not covered or allowable by insurance, together with collection costs, including reasonable attorney fees. I also understand that all bills are due and payable upon presentation. I understand that the patient responsibility portion of my bill shall be due and payable at the time of services.

Medicare
I hereby certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any such information needed for this or a related Medicare Claim. I request that the payment of authorized benefits be made on my behalf. I understand that I am responsible for any health insurance deductibles and co-insurance.

I, _____, by signing this document, acknowledge my consent to the above.

Signature: _____ Date: _____

Address:_____

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