Assignment of Benefits: ______

Initial Here

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private/auto insurance companies, and any other Health/Medical/Litigation plan, to issue payment check(s) directly to Synergy PT & Athletic Performance for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Financial Responsibility ______

Initial Here

I authorize Synergy PT and Athletic Performance to bill my insurance company directly for the covered portion of charges, and I authorize payment of medical benefits directly to Synergy PT and Athletic Performance. I authorize Synergy PT and Athletic Performance to release medical or other information necessary to process this claim. I understand that I am ultimately responsible for my physical therapy charges, and I agree to pay my deductible, my coinsurance, or copayment, and any charges not reimbursed by my insurance carrier. I understand that some insurance companies require medical or administrative authorization for treatment, or have reimbursement limits on physical therapy treatment. I understand I am responsible for knowing and meeting the requirements of my insurance plan. I understand that if my outstanding bill is sent to a collection agency or attorney, I am ultimately responsible for the total balance of my bill plus an additional 30% of the balance total.

I further understand that fees are due and payable on the date the services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

____ ____________________________

Patient/Responsible Party Signature Date

Consent for Treatment: ______

Initial Here

I hereby give permission to the treating staff of **Synergy PT and Athletic Performance** to perform physical therapy treatment for the condition I have been referred/the condition for which I seek treatment. This includes physical palpation and hands-on manual physical therapy. I understand that the treatment staff's clinical decision making will be explained to me and will be in accord to the established guidelines for physical therapy treatment by the VA Board of Health Professions and the American Physical Therapy Association. I also understand that it is my right as a patient to refuse any portion of my treatment and to ask questions, but realize that treatment may not be rendered if my refusal puts myself at risk or will negatively affect my physical therapy treatment.

Authorization to Release Information: ______

Initial Here

I hereby authorize Synergy PT & Athletic Performance to: (1) release/receive any and all information necessary for treatment and or payment from all insurance carriers and from the listed medical institutions below; (2) process insurance claims generated in the course of examination or treatment: and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

Release Medical information from the following facilities:

Name: ____

Name: ______________________________ ____

____ ______________________________

Patient/Responsible Party Signature Date