Patient Authorization	
Patient Name:	**Date of Birth**:

Release of Information & Consent for Treatment

All information provided herein is true and correct.
I am aware of my diagnosis and wish to receive treatment at Siegmund Physical Therapy.
I permit its employees and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care can include an evaluation, testing and treatment. No guarantees have been made to me about the outcome of this care.
I give permission to Siegmund Physical Therapy and its subsidiaries and affiliates to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees, and/or beneficiaries and all other related persons as it relates to my treatment and/or payment for services provided.
I authorize Siegmund Physical Therapy and/or its subsidiaries and affiliates to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.

The signature below certifies that I have read and understood the above information.

Initial:________________

Assignments of Benefits

I authorize payment directly to Siegmund Physical Therapy, its subsidiaries and/or affiliates for services and to bill and release payment directly to Siegmund Physical Therapy, its subsidiaries and/or affiliates for any physical therapy, occupational therapy, speech-language pathology, rehabilitation, orthotic or prosthetic services provided.
This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original.

Initial: ________________

Notice of Privacy Practices (HIPAA Acknowledgement of Consent)

I hereby acknowledge that I was offered a copy of The Notice of Privacy Practices for Siegmund Physical Therapy, its subsidiaries, and/or affiliates and understand the notice.
In addition, I hereby consent to the use and disclosure of *my* personal health information for the purpose of treatment, payment, and health care operations.

Initial: ________________

Patient Authorization
Payment Guarantee
I agree to pay Siegmund Physical Therapy, its subsidiaries and/or affiliates for the services provided to me or the party named above. If any law, such as workers' compensation, or insurance contract prohibits payment for these services I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for *speedy* collection from *my* third-party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances. The Benefit Verification form is only an explanation of coverage obtained from *my* insurance company and it is not a guarantee of coverage. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment for services. I further understand that this agreement is binding regardless of *any* legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of Siegmund Physical Therapy and/or its affiliates or subsidiaries. **Initial**: ________________
I give permission to leave a message on my answering machine. **Initial:** ________________
How would you like to be reminded of your appointments? e-mail address____ Text (cell phone number to be used)_______________________ **Initial**: _________
I give permission to discuss and share medical information with the following people: ________________________________, ________________________________, ________________________________, ________________________________, **Initial:** ________________
Patient or Guardian Signature: **Date**: