

New Heights Physical Therapy

Authorization for Treatment: I voluntarily consent to physical therapy encompassing evaluation and treatment procedures. I acknowledge that no guarantees have been made to me about the results of the exam and/or treatment to be provided in the this healthcare facility. I authorize New Heights Physical Therapy to provide such treatment. **Initials**_____

Payment Authorization: I request that payment be made on my behalf to New Heights Physical Therapy for services furnished to me by New Heights Physical Therapy to release to the Center for Medicare & Medicaid Services and its agents, and state Medicaid agency, and any third party payor all medical or other information that is needed to determine the benefits payable for health services. I agree to pay the charges for the care and treatment rendered to me that are not covered by insurance including any reasonable collection fees required to collect delinquent accounts. **YOUR HEALTHCARE PROVIDER, INSURER, OR PLAN MAY REQUIRE A PHYSICIAN REFERRAL OR PRIOR AUTHORIZATION AND YOU MAY BE OBLIGATED FOR PARTIAL OR FULL PAYMENT FOR PHYSICAL THERAPY SERVICES RENDERED.** **Initials**_____

Record Release: I hereby authorize New Heights Physical Therapy to release of any/all medical information acquired in the course of treatment to myself, my insurance company, employer, QRC or other healthcare agencies professionals, or persons who may provide healthcare services deemed necessary for continuing my medical care. **Initials**_____

Patient's Printed Name: _____

Date: _____ **Signature:** _____ **Of patient or Patient representative or parent/legal guardian. Relationship to patient:** _____

Consent for Treatment of Minors: New Heights Physical Therapy requires that a patient or legal guardian accompany any minor children (under 18 years of age) to their medical appointments. In the event that a parent or legal guardian is unable to accompany a minor child to a medical appointment, the parent or legal guardian must sign this Consent for Treatment of Minors to be kept on file at New Heights Physical Therapy and must also send a copy of a parent's photo ID (preferably a driver's license, however could be a utility bill showing proof of patient's home address). If we do not have written consent to treat at the time of the patient's first visit, we will attempt to call for verbal consent. If we are unable to reach a parent or guardian, we will not be able to initiate treatment.

Name of child: _____

Name of parent of legal guardian: _____

Address of parent/legal guardian: _____

Telephone number of parent/legal guardian: _____

I give New Heights Physical therapy permission to treat my child listed above and agree to reimburse New Heights Physical Therapy for the cost of rendering services to my child.

Date: _____ **Signature:** _____ **Of**

Patient or Patient representative or parent/legal guardian of minor. Relationship to Patient: _____

