ACTION PHYSICAL THERAPY
3443 Huntingdon Pike suite 2 Huntingdon Valley, PA 19006
215-947-3443 phone 215-947-4141 fax

Patient Authorization Record

Initial here	
	Authorization for Treatment ➢ I hereby give authorization for the performance of such rehabilitation procedures as permitted by *Action Physical Therapy* Statutes under the appropriate scope of practice are, in the judgment of my Therapist, deemed necessary.
	Authorization for Release of Information ➢ I agree that Action Physical Therapy may provide information from my medical record to persons involved in my medical care. ➢ I authorize the release of medical information necessary to obtain payment of any benefits available to me to Action Physical Therapy for services rendered. ➢ I agree that Action Physical Therapy may obtain information from others who have provided medical care to me and/or are responsible for the payment of all or part of my bills when this information is needed in order to treat, bill, and/or receive payment. ➢ I have read “Notice of Privacy Practices” mandated by HIPAA.
	Authorization for Release of Payment ➢ I authorize that direct payment of any benefits available to me be released to Action Physical Therapy for services rendered.
	Patient Agreement ➢ I agree to pay *Action Physical Therapy* charges for services rendered to me during my course of treatment. ➢ I agree to pay those charges which may not be paid by my health insurance and are my responsibility per my insurance benefit. If I do not pay for charges that are my responsibility, I agree to pay *Action Physical Therapy* collections costs including attorney and court fees.
	Medicare, Medicaid, and Similar Benefits ➢ I agree that the information given to *Action Physical Therapy* in applying for benefits under Medicare, Medicaid, and Maternal or Child Health services are complete and accurate. I agree that *Action Physical Therapy* may give Social Security Administration or its fiscal intermediary’s information necessary to process claims.
	Workers Compensation ➢ I agree that the information given to *Action Physical Therapy* in applying for benefits under Workers Compensation is complete and accurate. I agree that *Action Physical Therapy* may give intermediary’s information necessary to process claims.

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Patient signature   Date

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Printed patient name   Witness Signature   Date

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Signature of Legal Representative/POA