ARMADA
PHYSICAL THERAPY

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for **Armada Physical Therapy** to furnish medical care and treatment to _____ that is considered necessary and proper in diagnosing or treating his/her physical and mental condition.

_____ Responsible Party Initials/Date

AUTHORIZATION BENEFIT ASSIGNMENT-FINANCIAL RESPONSIBILITY-RELEASE OF INFORMATION

I authorize **Armada Physical Therapy** to release to the insurance carrier any information needed for the payment of any claim. I authorize payment to **Armada Physical Therapy** from my insurance carrier or third party payer.

I agree to pay any applicable co-payment at the time of service and coinsurance and/or deductibles as agreed between **Armada Physical Therapy** and me. I understand and agree that my insurance benefits may cover all charges and that I am responsible for those charges not covered by my health insurance or third payer. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

The above may not apply for those patients that are considered Worker's Compensation. However, be advised that if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for the services rendered to you.

A photocopy of this authorization is to be considered as valid as the original.

By my signature, I authorize **Armada Physical Therapy**, to release all information necessary, including medical records, to secure payment.

_____ Responsible Party Initials/Date

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I have had a full opportunity to read the **Armada Physical** Therapy Notice of Privacy Practices. I understand that by signing this consent to **Armada Physical Therapy** to use and disclose my protected health information to carry out treatment, payment activities and health care operations. I understand the terms of this notice may change time, and **Armada Physical Therapy** will always post the current notice at the clinic, on the website, and have copies available for distribution.

Indicated below are individuals whom **Armada Physical Therapy** may speak to regarding my treatment. Please list names.

□ Spouse_____ □ Father_____
□ Mother_____ □ Other_____

Listed below are individuals whom I request restriction regarding my protected health information.

□ Not Applicable □ _____

We may need to contact you. Do we have your permission to leave a confidential message at the phone numbers you provide us?

□ Yes if yes: Home #:_____ Mobile #:_____ Other #:_____
□ No

_____ Responsible Party Initials/Date

SIGNATURE FOR CONSENT

By my signature below, I acknowledge that I have read, understand and agree to the terms and conditions contained in **the Consent for Care and Treatment**, the **Authorization** to release all information necessary to secure payment, and **the Consent For Use** and **Disclosure of Health Information**.

Patient/Guardian/Responsible Party Signature: _____ **Date:_____**

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