Synergy Physical Therapy and Wellness

CONSENT FOR TREATMENT

I understand that I may have a condition requiring diagnostic procedures, physical examination, and/or medical treatment. I herby voluntarily consent to such procedures, physical examination, and such clinical treatment as deemed necessary by my health care providers. I further acknowledge that no guarantees have been made to me as to the results of treatment or examination provided by Synergy Physical Therapy and Wellness.

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

The undersigned herby authorized Synergy Physical Therapy and Wellness to disclose the patient's medical information to the referring physician, if any, and to the patient's health plan (such as Medicare, Medicaid, or insurance company) for the purposes of processing claims and to obtain payments on the account for services provided to the patient.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge that Synergy Physical Therapy and Wellness has presented and made available to me their Notice of Privacy Practices for protected health information.

MEDICARE RELEASE **MEDICARE NUMBER**_____

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize Synergy Physical Therapy and Wellness to release to the Centers for Medicare and Medicaid Services and its agents, any information needed to process my Medicare claims.

MEDICARE SUPPLEMENTAL INSURANCE

The undersigned herby authorizes Synergy Physical Therapy and Wellness to bill Medicare Supplemental Insurance payments for my medical care. I understand that _____ needs information about me, and my medical condition, to make decisions about payment. I request the above-named carrier to make payment of authorized Medicare Supplement benefits on my behalf to Synergy Physical Therapy and Wellness for any services furnished me and authorize any holder of medical information about me to release to the above-named carrier any information required to determine and pay these benefits.

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned herby agrees to assign and authorize payment of medical benefits directly to Synergy Physical Therapy and Wellness.

FINANCIAL AGREEMENT

The undersigned agrees, in consideration of the services to be rendered to the patient, to pay Synergy Physical Therapy and Wellness in accordance with the regular rate and office's payment policy.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGING AND IS THE PATIENT OR IS DULY AUTHORIZED BY OR ON BEHALF OF THE PATIENT, TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

_____ _____ _____

Print Patient's Name Patient's Signature Date

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