Turner Physical Therapy & Scoliosis Center, LLC

Patient Authorization/Agreement Record

Authorization for Treatment

- I hereby give authorization for treatment as deemed necessary by my physical therapist and permitted by *Maryland Statutes* scope of practice.

Authorization for Imaging/Release of Information

- I hereby give authorization to *Turner Physical Therapy & Scoliosis Center, LLC (TPT&SC)* to release medical information (including photographs) to those involved in my medical care.
- I hereby give authorization to *TPT&SC* to release medical information (including photographs) necessary to obtain payment of any benefits available to me for services rendered.
- I hereby give authorization to *TPT&SC* to 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 hereby give authorization to *TPT&SC* to photograph my person (adult or child), as deemed appropriate, and use for team collaboration with other healthcare professionals (orthotists, physicians, physical therapists, insurance companies, and others as needed) in my medical care.

Patient Confirmation for Receipt of Information

- I have been provided with a copy of the "Notice of Privacy Practices".
- I have been provided with a copy of the "Patients' Rights Policy".

Authorization for Release of Payment

- I request that payment of authorized Medicare/private insurance be made to me for any services provided to me by *TPT&SC*.

Patient Agreement to Pay for Services Rendered

- I agree to pay *TPT&SC* for services rendered to me during my entire course of treatment.
- I agree to pay those charges which may not be paid by my health insurance and are my responsibility per my "Out of Network" insurance benefit.
- I understand and agree that I am responsible for any service my insurance plan deems "non-covered", all coinsurance and/or co-payment amounts, all deductibles, any amount that exceeds benefit limits under my "Out of Network" insurance plan and any amount my insurance plan deems not covered because I was not insured on the date of service. If I do not pay for charges that are my responsibility, I agree to pay *TPT&SC* collections costs including attorney and court fees.

Medicare, Medicaid, and Similar Benefits

- I attest that the information provided to *TPT&SC about my medical coverage* is complete and accurate.
- I authorize *TPT&SC* to provide information necessary to those involved in order to process claims.

Workers Compensation

- I attest that the information given to *TPT&SC* in applying for benefits under Workers Compensation is complete and accurate. I agree that *TPT&SC* may give intermediary's information necessary to process claims.

Cancellation/No-Show Policy

- I agree to pay *TPT&SC* a $50.00 fee for no-shows and/or cancellations received less than 24 hours in advance of scheduled appointment time.

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Patient/Guardian Signature Date

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Printed Name

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Signature of Legal Representative/POA