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* to release medical information (including photographs) to those involved in my medical care.
- I hereby give authorization to *Turner Physical Therapy & Scoliosis Center, LLC* to release medical information (including photographs) necessary to obtain payment of any benefits available to me for services rendered.
- I hereby give authorization to *Turner Physical Therapy & Scoliosis Center, LLC* 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 *Turner Physical Therapy & Scoliosis Center, LLC* 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 hereby authorize that direct payment of any benefits available to me be released to *Turner Physical Therapy & Scoliosis Center, LLC* for services rendered.

Patient Agreement to Pay for Services Rendered

- I agree to pay *Turner Physical Therapy & Scoliosis Center, LLC* 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.
- 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 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 *Turner Physical Therapy & Scoliosis Center, LLC* collections costs including attorney and court fees.

Medicare, Medicaid, and Similar Benefits

- I agree that the information given to *Turner Physical Therapy & Scoliosis Center, LLC* in applying for benefits under Medicare, Medicaid, and Maternal or Child Health services are complete and accurate. I agree that *Turner Physical Therapy & Scoliosis Center, LLC* may give Social Security Administration or its fiscal intermediary's information necessary to process claims.

Workers Compensation

- I agree that the information given to *Turner Physical Therapy & Scoliosis Center, LLC* in applying for benefits under Workers Compensation is complete and accurate. I agree that *Turner Physical Therapy & Scoliosis Center, LLC* may give intermediary's information necessary to process claims.

Cancellation/No-Show Policy

- I agree to pay *Turner Physical Therapy & Scoliosis Center, LLC* a $50.00 fee for no-shows and/or cancellations received less than 24 hours in advance of scheduled appointment time.

_____

Patient/Guardian Signature Date

_____

Printed Name

_____

Signature of Legal Representative/POA