Name: ___________________________
DOB: ___________________________

Authorization Form

Please initial in each section below:

Consent to be treated. I hereby give consent to be evaluated and treated by the physical therapy staff of PT360, Inc. I understand that the treatment protocols used for my physical therapy are appropriate for my condition or injury.

Billing Authorization.

- I authorize release of all information necessary to verify and process a claim for insurance benefits. I further irrevocably authorize that all payments for treatments be made directly to PT360, Inc.
- If PT360 has a contract with your insurance company, all terms and conditions of that contract apply. If PT360 does not have a contract with your insurance company, PT360° is not bound to the terms and conditions of your policy.
- Accounts 90 days and over are subject to a finance charge of 1.5% per month (annual percentage of 18%). Should this account be sent to a licensed collection agency, a 15% service charge will be added to your balance. All collection costs (including but not limited to) any attorney fees and court costs are the responsibility of the patient.

Notification of Insurance Changes or Updates such as Workman's Comp and Motor Vehicle Claims. I understand that my health insurance requires notification at the start of treatment in the event they have to provide coverage. If I choose not to provide this information, I understand that my health insurance will not be responsible for any past charges and I will be liable for payment.

Attendance. I have received/been offered a copy of the PT360 Cancel/No Show Policy.

HIPAA. I have received/been offered a copy of the PT360 HIPAA/Privacy statement.

Others that I wish to release my health information to (i.e. spouse, partner, parents, trainer, etc.):

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____ ______________________
Patient Signature/Legal Guardian (if patient is under 18) Date

____ ______________________
Witness Date