Authorization Form

Name:_____
DOB: _____

Please initial in each section below:

_____**Consent to be treated.** I hereby give consent to be evaluated and treated by the physician 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. **In addition, I understand and agree to assume full financial responsibility for all charges issued.**
  - **Including services that are not cover by my insurance at a charge of :**_____
    _____

- **All co-pays are due upon check-in for your appointment**.

- 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.

_____ **Workman's Comp and Motor Vehicle Claims (only).** 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.):
_____
_____

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

_____ _____
Witness Date