



# 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 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 I am not eligible for coverage, I understand that I am liable for charges for services rendered.**
  - **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** I wish to release my health info to: (i.e. **primary care physician**, spouse/partner, parents, trainer, etc.).
- Release of **billing information**, i.e. to person responsible for paying your billing (i.e. spouse/partner, parent)

\_\_\_\_\_  
Patient Signature/Legal Guardian (if patient is under 18)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date