

**SOUTH FLORIDA PHYSICAL THERAPY ASSOCIATES
(PATIENT CONSENT AUTHORIZATION)**

CONSENT FOR TREATMENT: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician (s).

ASSIGNMENT OF BENEFITS: I hereby assign payment directly to the physician (s) Accepting this assignment of medical benefits applicable and otherwise payable to me but not to exceed the physician's regular charges. I understand that I am financially responsible for charges not covered by this assignment or for any and all charges that the insurance carrier declines to pay.

RELEASE OF INFORMATION: The physician(s) may disclose all or part of the patient's record to any corporation which is or may be liable under a contract to the physician(s) or to the patient, or to a family member or employer of the patient for all part or part of the physician(s) charges, including but not limited to, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

H.M.O DISCLAIMER: I certify that I am not presently enrolled in any Health Maintenance Organization (HMO). Subsequent rejection of a claim as a result of this admission, due to current enrollment in an H.M.O. plan will constitute responsibility for payment of claim on my part.

**MEDICARE & MEDICAID PATIENT CERTIFICATION AND AUTHORIZATION TO
RELEASE INFORMATION AND PAYMENT REQUEST:**

I certify that the information given by me in applying for payment under the Title XVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration of its intermediary carriers, any information needed for this or related Medicare or Medicaid benefits payable for physician(s) services. I understand that I am responsible for my Health Insurance deductibles and coinsurance.

Verification of non-pregnancy

Date _____ File# _____ X _____

Print Patients Name

Date of L.M.P _____

**By my signature on this form, I do hereby
State that to the best of my knowledge, I
Am not pregnant, nor is pregnancy suspected
Or confirmed at this particular time.**

Patient's Signature

**Other than Patient, Print name and
Relationship**

X _____
Witness