Patient Name: ____

Authorization for Treatment

I hereby authorize Hands on Healing Physical Therapy to provide physical therapy treatment and services to myself or above named patient. I also authorize the release of such information that may be necessary for my care via mail, electronic or facsimile transmission.

Release and Assignment of Benefits

I hereby authorize Hands on Healing Physical Therapy (HOH) to bill my insurance company directly for the covered portion of charges, and I authorize payment of medical benefits directly to HOH. I authorize HOH to release medical or other information necessary to process this claim. I understand that I am ultimately responsible for my physical therapy charges, and I agree to pay my deductible, co-payment or co-insurance, and any charges not reimbursed by my insurance carrier. I understand that some insurance carriers require medical or administrative pre-authorization for treatment, or have reimbursement limits on physical therapy treatment. I understand I am responsible for knowing and meeting the requirements of my insurance plan.

____ ___________

Signature of Patient or Responsible Party Date

Emergency Contact Information:

Emergency Contact: ___________________________________Relation: ______________________

Phone Number: ___________________________Other Phone: ________________________________

Text/E-Mail Reminders

We are excited to offer text and e-mail reminders of your appointments. If you would like to be included in these reminders, please complete the following information. You can select either option or both if you prefer.

☐ Please send me e-mail reminders of my appointments.

My E-mail address is: ____

☐ Please send me text reminders of my appointments.

My cell phone number is: ____

My Cell Carrier is: ____

____ ___________

Signature of Patient or Responsible Party Date