MEDICAL AND FINANCIAL INFORMATION AUTHORIZATION AND RELEASE

The purpose of this Authorization and Release is for your protection. H.I.P.A.A. stands for Health Insurance Portability and Accountability Act. This act was created for the sole purpose of protecting patient medical records and financial information. We request that you complete the information below and allow us to better protect the privacy of your medical information. We appreciate your attention to this matter. Please be specific when you indicate your choices. If you would like further information, please let us know.

I authorize the staff of Registered Physical Therapists, Inc. to release any **financial** information to the following people and or businesses.

Name of Spouse/Partner: ____

Parent or Guardian: ____

Other: ____

(e.g. Employer, Coach, Child)

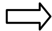
I authorize the staff of Registered Physical Therapists, Inc. to release any **medical** information to the following people and or businesses.

Name of Spouse/Partner: ____

Parent or Guardian: ____

Other: ____

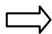
(e.g. Employer, Coach, Child)



____________________________________	____________________
Patient Signature	Date
____________________________________	____________________
Parent or Guardian if patient is under 18	Date

ASSIGNMENT AND RELEASE OF INFORMATION

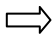
I hereby authorize my insurance company to make payment directly to Registered Physical Therapists, Inc. (RPT) I further authorize RPT to release information to my insurance company to process payment of my claims and any other company or person listed above.



____________________________________	____________________
Patient Signature	Date
____________________________________	____________________
Parent or Guardian if patient is under 18	Date

FINANCIAL AGREEMENT

I have read and understand Registered Physical Therapists Financial Policy.
I understand that I am responsible for payment of my account. RPT will file my claims with my insurance company as a courtesy.



____________________________________	____________________
Patient Signature	Date
____________________________________	____________________
Parent or Guardian if patient is under 18	Date