

 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 serve and protect the privacy of your medical information. We appreciate your attention to this matter. Please be specific when you indicate your choices.

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)

 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.

 FINANCIAL AGREEMENT

I understand that I am responsible for payment of my account, RPT will file my claims with my insurance company as a courtesy. If collection or legal action is required, I understand that I will be responsible for collection and/or attorney's fees if any delinquent balance is placed with an agency for collection or suit. If my account is turned over to a collection agency I will be responsible for an additional \$20.00. If I do not respond to pre-collect measures and legal action is taken I will be responsible for an additional 50%. (For more details please see our payment and insurance billing policies included in your new patient packet)

Patient Signature

Date

Parent or Guardian if patient is under 18

Date