

Personalized Therapy, LLC

Occupational & Physical Therapy for Children & Adults

PATIENT AUTHORIZATION

Patient Name:

RELEASE OF INFORMATION & CONSENT FOR TREATMENT

All information provided herein is true and correct.

I am aware of my diagnosis and wish to receive treatment at Personalized Therapy, LLC. I permit its employees and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care can include an evaluation, testing and treatment. No guarantees have been made to me about the outcome of this care.

I give permission to Personalized Therapy, LLC to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employers, related healthcare provider, assignees and/or beneficiaries and all other related persons as it related to my treatment.

I authorize Personalized Therapy, LLC to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.

The signature below certifies that I have read and understand the above information

Patient or Guardian Signature:

Date:

ASSIGNMENT OF BENEFITS

I authorize payment directly to Personalized Therapy, LLC for services rendered.

This direct assignment of my rights and benefits under this policy.

A photocopy of this assignment shall be considered as effective and valid as the original.

Patient or Guardian Signature:

Date:

NOTICE OF PRIVACY PRACTICES (HIPPA)

I hereby acknowledge that I have received a copy of The Notice of Privacy Practices for Personalized Therapy, LLC.

I hereby consent to the use and disclosure of my personal health information of the purposes of treatment, payment, and healthcare operation.

I hereby consent for Personalized Therapy to notify me via phone/phone message of my scheduled appointments.

Patient or Guardian Signature:

Date:

22593 THREE NOTCH ROAD • CALIFORNIA, MD • 20619
PHONE: 301.862.2505 • FAX: 301.862.2548

Personalized Therapy, LLC

Occupational & Physical Therapy for Children & Adults

PATIENT AUTHORIZATION

PAYMENT GUARANTEE

I hereby acknowledge that I have received a copy of The Financial Policy for Personalized Therapy, LLC.

I agree to pay Personalized Therapy, LLC for the services provided to me or the party named above. If any law, such as workers compensation, or insurance contract prohibits payment for these services I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances.

The Benefit Verification form is only an explanation of coverage obtained from my insurance company and it is not a guarantee of coverage. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment for services.

I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of Personalized Therapy, LLC.

Patient or Guardian Signature:

Date:

RELEASE FOR MEDIA RECORDING

I hereby grant or deny permission to Personalized Therapy, LLC to use my image or the image of my child _____, as marked by my selection(s) below. Such includes the display, distribution, publication, transmission, or otherwise use of photographs, images, and/or video taken of my child for use in material that include, but may not be limited to, printed materials such as brochures and newsletters, videos, and digital images such as those on the Personalized Therapy, LLC website.

- Deny Permission Grant Permission for use of image in the following ways (mark all that apply)
- Limited Usage: I want the image used within the Personalized Therapy, LLC setting only (not in larger community)
- Limited Usage: I want the image used for educational materials only (not marketing). This could be either within Personalized Therapy, LLC or in the larger community. (i.e.: videos in parent education classrooms)
- Limited Usage: I want the image used on printed materials only (no video use)
- Unrestricted Usage: I give unrestricted permission for the image to be used in print, video, and digital media. I agree that these images may be used by Personalized Therapy, LLC for a variety of purposes and that these images may be used in conjunction with any video or digital images.

Patient or Guardian Signature:

Date:

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