Therapeutic Hands
Orthopedic Home Physical Therapy, Inc.

Consent for Treatment

All Patients

Request for admission. Consent for treatment and authorization for treatment.

I request services from Therapeutic Hands Physical Therapy and consent to such treatment as ordered by my physician. I understand that my care is directed by the attending physician and that Therapeutic Hands is not liable for any act or omission when following the instructions of said physician, who is neither the employee nor the agent of Therapeutic Hands Orthopedic Home Physical Therapy. I hereby consent to the release of information by any health care provider, including any physician, hospital, skilled nursing facility, home health care agency, or rehabilitation agency, in which I have been a patient and to disclose all or any part of my medical record to Therapeutic Hands.

Patient Name (print)_____

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Signature_____Date_____

Medicare

Patient Certification: Authorization to Release Information Payment Request;

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made in by behalf.

Assignment of Primary/Supplemental Insurance Benefits:

I hereby authorize payment directly to Therapeutic Hands of any insurance benefits payable to me. I understand that I am financially responsible to Therapeutic Hands for any deductible or coinsurance not paid by the insurance company. The undersigned certifies that he/she has read the foregoing and is the patient, or is duly authorized by the patient to execute the above and accept its terms.

Signature_____Date_____