Patient Authorization Record

Initial Each Box Below	
	Authorization for Treatment ➢ I hereby give authorization for the performance of such rehabilitation procedures as permitted by Indiana Statutes under the appropriate scope of practice and, in the judgment of my Therapist, deemed necessary.
	Authorization for Release of Information ➢ I agree that Steppin' Up Physical Therapy may provide information from my medical record to persons involved in my medical care. ➢ I authorize the release of medical information necessary to obtain payment of any benefits available to me to Steppin' Up Physical Therapy for services rendered. ➢ (Optional) I also give consent to release health or financial information to the following: (If a friend or relative calls to ask how you are recovering or comes to pick up records or bill for treatment, we cannot provide this without your consent.) Name:__________________ Relationship:________________ D.O.B. __________ Name:__________________ Relationship:________________ D.O.B. __________ Name:__________________ Relationship:________________ D.O.B. __________ ➢ I agree that Steppin' Up Physical Therapy may obtain information from others who have provided medical care to me and/or are responsible for the payment of all or part of my bills when this information is needed in order to treat, bill, and/or receive payment. ➢ I have read "Notice of Privacy Practices" mandated by HIPAA.
	Authorization for Release of Payment ➢ I authorize that direct payment of any benefits available to me be released to Steppin' Up Physical Therapy for services rendered.
	Patient Agreement ➢ I agree to pay Steppin' Up Physical Therapy charges for services rendered to me during my course of treatment. ➢ I agree to pay those charges which may not be paid by my health insurance and are my responsibility per my insurance benefit. If I do not pay for charges that are my responsibility, I agree to pay Steppin' Up Physical Therapy collections costs including attorney and court fees.
	Medicare, Medicaid, and Similar Benefits ➢ I agree that the information given to Steppin' Up Physical in applying for benefits under Medicare, Medicaid, and Maternal or Child Health services are complete and accurate. I agree that Steppin' Up Physical may give Social Security Administration or its fiscal intermediary's information necessary to process claims.
	Workers Compensation ➢ I agree that the information given to Steppin' Up Physical Therapy in applying for benefits under Workers Compensation is complete and accurate. I agree that Steppin' Up Physical Therapy may give intermediary's information necessary to process claims.

____

Patient signature   Date

____

Printed patient name   Date

____

Signature of Legal Representative/POA

To opt for unencrypted (unsecured) e-mail communications please provide your e-mail address:____. By opting for unencrypted e-mail communications you must understand that the communications will not be protected or secured and that Steppin' Up will **NOT** be responsible for further disclosure or misuse of your information.

Patient's signature: ____

Authorization of E-mail Communication.