



Facility Use Only	
Facility #:	Account#:
Date of Eval:	Therapist:

Patient Authorization

Patient Name:	
Release of Information	
All information provided herein is true and correct.	
I hereby consent to treatment.	
I give permission to Georgia Physical Therapy and Sports Medicine Center and its subsidiaries and affiliates to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment.	
I authorize Georgia Physical Therapy and Sports Medicine Center and/or its subsidiaries and affiliates to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.	
Information without patient identifiers may be used for quality assurance purposes.	
I have read and understand the above release.	
Patient or Guardian Signature:	Date:

Assignment of Benefits:	
I authorize payment directly to Georgia Physical Therapy and Sports Medicine Center, its subsidiaries and/or affiliates for services.	
This is a 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 Acknowledgement/Consent)	
I hereby acknowledge that I have received a copy of The Notice of Privacy Practices for Georgia Physical Therapy and Sports Medicine Center.	
In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and health care operations.	
Patient or Guardian Signature:	Date:

Payment Guarantee	
I agree to pay Georgia Physical Therapy and Sports Medicine Center, its subsidiaries and/or affiliates 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 Georgia Physical Therapy and Sports Medicine Center and/or its affiliates or subsidiaries.	
Patient or Guardian Signature:	Date: