

Patient Authorization Record

Initial here

	<p><u>Authorization for Treatment</u></p> <ul style="list-style-type: none"> ➤ I hereby give authorization for the performance of such rehabilitation procedures as permitted by New York State Statutes under the appropriate scope of practice are, in the judgment of my Therapist, deemed necessary.
	<p><u>Authorization for Release of Information</u></p> <ul style="list-style-type: none"> ➤ I agree that Greco Physical Therapy & Sports Performance, PLLC (GPT) 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 GPT for services rendered. ➤ I agree that GPT 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.
	<p><u>Authorization for Release of Payment</u></p> <ul style="list-style-type: none"> ➤ I authorize that direct payment of any benefits available to me be released to GPT for services rendered.
	<p><u>Patient Agreement</u></p> <ul style="list-style-type: none"> ➤ I agree to pay GPT 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 GPT collections costs including attorney and court fees.
	<p><u>Medicare, Medicaid, and Similar Benefits</u></p> <ul style="list-style-type: none"> ➤ I agree that the information given to GPT in applying for benefits under Medicare, Medicaid, and Maternal or Child Health services are complete and accurate. I agree that GPT may give Social Security Administration or its fiscal intermediary's information necessary to process claims.
	<p><u>Workers Compensation</u></p> <p>I agree that the information given to GPT in applying for benefits under Workers Compensation is complete and accurate. I agree that GPT may give intermediary's information necessary to process claims.</p>

Patient signature

Date

Printed patient name

Witness Signature

Date

Signature of Legal Representative/POA