

Patient Registration

**BACK TO ACTION
PHYSICAL THERAPY
PLC**

Waitsfield Vermont

PATIENT AUTHORIZATION FORM

Acknowledgement of Notice of Privacy Practices

I have reviewed and been offered a copy of the Back To Action Physical Therapy, PLC Notice of Privacy Practices. Back To Action Physical Therapy is required to give me a copy of this notice by the Federal HIPAA (Health Insurance Portability and Accountability Act) Law.

Signature: _____

Date: _____

Payment Authorization

Payment of medical benefits may be made on my behalf to Back To Action Physical Therapy, PLC for any services furnished to me by the provider. **I understand that in accepting medical services, I am also accepting responsibility for the payment for those services.** I agree to pay for any and all costs for which my insurance company denies payment. Should the balance of the account exceed an amount the undersigned is able to pay in full, an agreed payment plan can be established by speaking with the Billing Manager.

Signature: _____

Date: _____

Release of Medical Information Authorization

I authorize Back To Action Physical Therapy, PLC to release my medical and other information to my insurance company, as stated in my policy. I also authorize release of medical and other information to any other medical professional, when appropriate. I also authorize Back To Action PT to discuss my care with or provide information to the following persons. Please include any family members you wish us to be able to speak with regarding your care.

Signature: _____

Date: _____

Our Expectations of Patients

I understand that if I am unable to attend a scheduled appointment I need to CALL 24 hours in advance – or as soon as possible. I understand I will be billed a \$45.00 “NO SHOW FEE” for any non-cancelled appointments. This will be billed to you personally, not to your insurance. This measure is to dissuade patients from expending valuable time that could be utilized by other patients.

I understand that cell phones are to be turned off or on silent upon arriving to the clinic.

I acknowledge that I have received a copy of the Back To Action Billing Information handout and that I am responsible for knowing what costs my insurance plan will cover.

I understand that bills will be sent in the name of the patient, even if the patient is a minor.

Signature: _____

Date: _____