PATIENT NAME: _____

Authorization for Treatment

I hereby authorize Focused Physical Therapy to provide rehabilitation procedures within the scope of practice deemed appropriate by Maryland Statutes.

Authorization for Release of Payment/Assignment of Benefits

I authorize that direct payment of any benefits available to me be released to Focused Physical Therapy for services rendered.

Authorization for Release of Information

I authorize Focused Physical Therapy to release information, verbal or written, pertaining to my treatment, and other related information, to my doctor, specialist, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and any other individuals as it relates to my treatment. Focused Physical Therapy is also authorized to obtain medical records and/or professional information from medical professionals as it relates to my treatment. In addition, Focused Physical Therapy is authorized to contact me via telephone or email regarding future appointments and/or other treatment related issues.

Notice of Privacy Practices (HIPPA Acknowledgement/Consent)

I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and health care operations.

I have read the above and understand the information provided. I authorize treatment, and the release of information as noted above. I also authorize Assignment of Benefits, and acknowledge I have received the HIPPA Notice of Privacy Practices. Photocopy of this document is as valid as the original.

Patient or Guardian Signature: _____ **Date:** _____

Focused Physical Therapy
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