Patient Authorization and Guarantee

RELEASE OF INFORMATION

I hereby authorize the release of any information by telephone or in writing. Including reports of diagnosis, treatment, prognosis, recommendation, benefits payable, as well as any other data pertinent to my treatment, by Physical Therapy and Fitness Center of Raynham Inc. to my physician(s), as well as any organization responsible for payment of my account, and any legal representative involved in my litigation. I also authorize the release of information by telephone or in writing for utilization and quality review purposes.

ASSSIGNMEBT OF INSURANCE BENEFITS

I hereby authorize that the payment of authorized benefits be made directly to Physical Therapy and Fitness Center of Raynham Inc. for any services that are reimbursable by Medicare, Medicaid, or any third party sources.

VALUABLES

I hereby understand that Physical Therapy and Fitness Center of Raynham is not responsible for valuables and personal property brought to the facility.

CONSENT OF TREATMENT

I hereby consent to such treatment procedures and patient care which, in the judgment of the treating clinician, may be considered necessary or advisable while I am a patient of Physical Therapy and Fitness Center of Raynham Inc.

GUARANTEE OF ACCOUNT

In consideration of services rendered to me by Physical Therapy and fitness Center of Raynham, I hereby guarantee payment for any and all services rendered to me in which are not covered or allowable by insurance, together with collection costs, including reasonable attorney fees. I understand that there may be a charge for supplies that are needed during the course of my treatment that will not be covered by my insurance and for which I am financially responsible. I also understand that I may have a co-payment, co-insurance and/or deductible which I am fully responsible for paying. Although Physical Therapy and Fitness Center will inform me of my insurance coverage for physical therapy, it is ultimately my responsibility to understand my insurance benefit limitations and payments. I will immediately notify Physical Therapy and Fitness Center of Raynham of any changes in my insurance coverage while receiving physical therapy.

Medicare

I hereby certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any such information needed for this or related Medicare claims. I request that the payment of authorized benefits be made on my behalf. I understand that I am responsible for any health insurance deductibles and co-payments.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have seen the "Notice of Privacy Practices" I understand that I may ask questions about the "Notice of Privacy Practices' at any time.

I__________________________________, by signing this document, acknowledge my consent to the above:

Signature____ Date________________