CONSENT TO TREATMENT

I hereby authorize the professional staff at ***Elite Sports and Physical Therapy*** to examine and treat me with physical therapy for the injury I have been referred here for or referred myself to. I further consent to have my minor child treated by the staff of ***Elite Sports and Physical Therapy*** while I am not physically in the facility.

______________________________	______________________________	______________
Patient Name (Printed)	Patient Signature	Date
______________________________	______________________________	______________
Parent/Guardian Name (Printed)	Parent/Guardian Signature	Relationship
______________________________	______________	
Witness	Date	

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO HEALTH PROVIDER

Insurance Company/Companies Name(s) ____.

I hereby instruct the above named insurance company/companies to pay by check made out to and mailed directly to: ***Elite Sports and Physical Therapy*** for professional or medical expenses allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy. I understand that ***Elite Sports and Physical Therapy*** complies with HIPAA and will protect my Protected Health Information (PHI) and will use it as allowable by law in the treatment, billing and collection pertaining to my care until my case is closed and full payment is received. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney for the purpose of securing payment under this policy of insurance or to any Medical Provider associated with my case to effectively treat me. The authorization is in effect until 90 days from the date the last bill is collected.

HIPAA REGULATIONS A photocopy of this Assignment shall be considered effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney for the purpose of securing payment under this policy of insurance under the HIPAA guidelines.

______________________________	______________________________	______________
Patient Name (Printed)	Patient Signature	Date
______________________________	______________________________	______________
Parent/Guardian Name (Printed)	Parent/Guardian Signature	Relationship
______________________________	______________	
Witness	Date	