Patient Authorization Record for Regen Physical Therapy, LLP

Authorization for treatment: I hereby give authorization for the performance of such rehabilitation procedures as permitted by NY Statues under the appropriate scope of practice, in the judgment of physical therapist, deemed necessary.

Authorization for Release of Information: I agree that the Regen Physical Therapy may provide information from my medical record to persons involved in my medical care. I authorize release of medical information necessary to obtain payment for Regen Physical Therapy of any benefits available for services rendered. I agree that Regen Physical Therapy 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 authorize release to third parties (including the social security administration or its fiscal intermediaries, when applicable) any medical or other information necessary to determine insurance benefits and process claims.

Authorization for Release of Payment: I request payment of authorized insurance and/or government benefits (Medicare, Medicaid, etc.) be made directly to Regen Physical Therapy.

Patient Agreement: I agree to pay Regen Physical Therapy charges for services rendered to me during my course of treatment (i.e. copay, coinsurance, self-pay). I agree to pay those charges which may not be paid by my health insurance and are my responsibility. If I do not adhere to this agreement, I agree to pay Regen Physical Therapy collection costs including attorney and court fees.

Adherence to No Show Policy: Effective January 1, 2015, patients who fail to present for a scheduled appointment, without contacting the practice at least the day prior to their appointment, will be considered a "no show" and will be charged a fee of $35.00 on their second missed appointment. This fee will be charged directly to the patient and must be paid at the time of the next visit. I agree to pay this fee if applicable.

Printed Patient Name:

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Patient Signature: _____

Date: _____