MEDICARE PATIENTS COMPLETE THIS SECTION:

I, (signature) _____, request that payment under the Medicare insurance program be made to Orcas Island Physical Therapy, PLLC for any bills for services furnished to me during the effective period of this authorization and I authorize the above named provider to release to the Social Security Administration, or its intermediaries or carriers, any information needed for this claim or any related Medicare claim. I further permit a copy of this authorization to be used in place of the original.

I, (signature) _____, understand that the Centers for Medicare and Medicaid Services (CMS) has ruled that patients in their system are allowed to receive prescribed physical therapy treatments up to a period of ninety (90) days (beginning with the initial physical therapy visit) after which they are required to visit their physician (face-to-face) for re-evaluation. Continuing prescribed physical therapy will require doctor visits every thirty (30) days thereafter.

PLEASE, ALL PATIENTS COMPLETE THIS SECTION:

I, (signature)_____ , consent to treatment and authorize the use of this signature on insurance claims pertinent to physical therapy treatments received at Orcas Island Physical Therapy, PLLC. I understand that, as a courtesy, Orcas Island Physical Therapy, PLLC will bill my insurance company and that I am personally responsible for any co-pays, deductible or balances remaining after insurance consideration.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

I, (signature)_____, understand that Orcas Island Physical Therapy, PLLC keeps a record of the physical therapy services provided me. I may ask to see these records, copy them or correct them. Orcas Island Physical Therapy, PLLC will not disclose my records to others unless directed by me to do so, or unless the law authorizes or compels them to do so.

NAME **PRINTED:** _____ DATE: _____

ORCAS ISLAND PHYSICAL THERAPY, PLLC
PO BOX 487 / 49 DEYE LANE EASTSOUND, WA 98245 PH 360.376.6604 / FAX 360.376.4059