OPTIMAL SPORTS
physical therapy

Release of Information, Payment Authorization, and Consent to Treatment

Consent to Treatment: I voluntarily give my content to Optimal Sports Physical Therapy, LLC to evaluate and treat my condition.

Initials _____

Records Release: I hereby authorize the release of any information, including medical and billing information, by Optimal Sports Physical Therapy, LLC to my referring doctor, insurance company, billing service (Beacon Accounts Management), the responsible party named on my account, and immediate family of myself and/or dependents.

Initials _____

Assignment of Benefits and Guarantee/ Agreement to pay: I hereby authorize payment of medical benefits from any insurance coverage to be assigned & paid directly to **Optimal Sports Physical Therapy, LLC** for services rendered to myself and/or dependents. I agree to pay the charges for the care and treatment rendered to me not covered by my insurance plan, or in the absence of insurance coverage (or, if signed by someone other than the patient, to guarantee payment for the care and treatment rendered to the patient named on this document).

Date: _____ Signed X_____
Patient, Legal Representative or Guarantor

Medicare Authorization: I request that payment of authorized Medicare benefits on my behalf, be paid directly to **Optimal Sports Physical Therapy, LLC** for any services rendered me by that clinic or physical therapist. This authorization includes payments from any Medicare supplement coverage I may have.

I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in the place of the original.

I understand that I am financially responsible for any charges not covered by Medicare.

Date: _____ Signed X_____
Patient, Legal Representative or Guarantor