Total Body Rehab

1210 S.E. Maynard Rd. ♦ Suite 103♦ Cary, NC 27511♦ **919-297-0280 – tel ♦ 919-297-0281 - fax**

Patient Authorization Record

Initial here	
	Authorization for Treatment ➢ I hereby give authorization for the performance of such rehabilitation procedures as permitted by North Carolina Statutes under the appropriate scope of practice are, in the judgment of my Therapist, deemed necessary.
	Authorization for Release of Information ➢ I agree that Total Body Rehab may provide information from my medical record to persons involved in my medical care. ➢ I authorize the release of medical information necessary to obtain payment of any benefits available to me to Total Body Rehab for services rendered. ➢ I agree that Total Body Rehab 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 have read "Notice of Privacy Practices" mandated by HIPAA.
	Authorization for Release of Payment ➢ I authorize that direct payment of any benefits available to me be released to Total Body Rehab for services rendered.
	Patient Agreement ➢ I agree to pay Total Body Rehab charges for services rendered to me during my course of treatment. ➢ I agree to pay those charges which may not be paid by my health insurance and are my responsibility per my insurance benefit. If I do not pay for charges that are my responsibility, I agree to pay Total Body Rehab collections costs including attorney and court fees.
	Medicare ➢ I agree that the information given to Total Body Rehab in applying for benefits under Medicare are complete and accurate. I agree that Total Body Rehab may give Social Security Administration or its fiscal intermediary's information necessary to process claims.
	Blue Cross and Blue Shield of North Carolina ➢ I agree that Total Body Rehab is not in network with BCBS of NC. I agree to pay for services at the time they are rendered to Total Body Rehab and that I will receive payment directly from BCBSNC. Total Body Rehab with submit claim forms on my behalf to BCBSNC. I agree that Total Body Rehab may give intermediary's information necessary to process claims.

Patient signature Date

Printed patient name Witness Signature Date

Signature of Legal Representative/POA