Sunshine Physical Therapy PC

Consent for Treatment and Authorization for Payment to Provider

I, the patient, being mentally competent, am requesting physical therapy either on the advice of my healthcare provider, or based on my own judgment of my needs. I understand there is always the possibility of some risk involved in medical treatment, but consent to evaluation and treatment to be provided by Sunshine Physical Therapy, PC.
I authorize Sunshine PT to release to Medicare, its intermediaries, and/or other health insurance plans, any information needed for this claim or related claims.
I also authorize my insurance benefits to be paid directly to Sunshine Physical Therapy, PC. I understand that I am financially responsible for any co-pay, co-insurance, or deductible amounts, and any balance left outstanding after adjustments and payments by my insurance have been made. I also authorize Sunshine Physical Therapy, PC to release any information required to process insurance claim transactions.

Insurance Information
Are you covered by insurance?
Yes No
Name of Insurance company: ________________________

Policy#________________________ Name of policy holder: ______________________

Date of Birth of policy holder: _____________

Patient's Relationship to Policy Holder:
Self Spouse Child Other

Claim Number (applicable in cases of worker's compensation or auto accident injury, or cases of injury where a claim is made against a 3rd party insurance):_________________

Does any other insurance have responsibility for medical bill coverage? If so, please List: ____

Person responsible for bill if other than patient:
Name:__________________________________
Birth Date:______________________________
Address: ____
Phone#: Home:____________________________Work:__________________________

Patient Name: ___________________________

The above information is true to the best of my knowledge:

Signature: ____________________________ Date: ________________