

**AUTHORIZATION TO RECEIVE A COMPLIMENTARY CONSULTATION**

I, the undersigned, agree to a Complimentary Consultation at BODYWORKS. I understand that this Consultation is not a substitute for an Evaluation and is provided to me as a professional courtesy. By initialing below, I acknowledge this fact and give the Physical Therapist permission to speak with me; perform a physical screening examination; and advise me on further treatment options. Neither I nor my insurance company will be billed for this service.

Initials: \_\_\_\_\_ Date: \_\_\_\_\_

**AUTHORIZATION TO RECEIVE AN EVALUATION**

I, the undersigned, agree to an Evaluation at BODYWORKS. I understand that the Evaluation will determine my diagnosis, prognosis, and outcome of treatment. By returning for subsequent appointments, I demonstrate my authorization to receive and participate in a treatment program in accordance with the facility operating policies, of which I will be given a written copy.

Initials: \_\_\_\_\_ Date: \_\_\_\_\_

**AUTHORIZATION TO RELEASE MEDICAL INFO TO HEALTH CARE PROVIDERS INVOLVED IN YOUR TREATMENT**

I, the undersigned, agree to the release of only pertinent medical records, X-rays, information regarding my medical condition, verbal reports, history, physical condition, and treatment rendered, to other health care professionals involved in my care. I will be provided with a written copy of PRAXIS Corporation's policy of the Health Insurance Portability and Accountability Act of 1996 (HIPPA) with regard to Protected Health Information (PHI).

Initials: \_\_\_\_\_ Date: \_\_\_\_\_

**AUTHORIZATION TO RELEASE OR RECEIVE MEDICAL INFORMATION VIA MAIL, ELECTRONIC MAIL (SUCH AS E-MAIL LOCAL INTRANETS, THE INTERNET AND "WORLD WIDE WEB" FOR NECESSARY MEDICAL CORRESPONDENCE)**

I, the undersigned, hereby authorize BODYWORKS to release/receive only pertinent medical records and information regarding my medical condition, history, physical condition, prior authorizations, insurance billing and treatment rendered. I understand that the reason for Internet use is to allow more rapid action and decision-making to assist in my care. I will be provided with a written copy of PRAXIS Corporation's policy of the Health Insurance Portability and Accountability Act of 1996 (HIPPA) with regard to Protected Health Information (PHI).

Initials: \_\_\_\_\_ Date: \_\_\_\_\_

**AUTHORIZATION TO ASSIGNMENT OF BENEFITS AND ACCEPTANCE OF FINANCIAL RESPONSIBILITY**

I, the undersigned, have medical insurance coverage and assign directly to BODYWORKS/PRAXIS CORPORATION medical benefits, if any, payable to me for services rendered. I will be provided with and read a copy of BODYWORKS' financial policies. I understand that I am responsible for all charges whether paid for by my insurance or not. I authorize the release of only pertinent medical information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment. In addition, I understand that PRAXIS Corporation reserves the Right to Recover attorney fees and costs associated with the collection of my account in the event that my account is placed with a collection agency to recover the balance and principal due.

Initials: \_\_\_\_\_ Date: \_\_\_\_\_

Patient/Claimant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Legally Authorized Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_\_

**Note: The above authorizations will be in effect unless revoked by written notification from the patient.**