

**Southwind Physical Therapy Inc.**

**Consent and Authorization Form**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I am giving consent for treatment by Southwind Physical Therapy Inc. Initial: \_\_\_\_\_

I am authorizing Southwind Physical Therapy Inc. to release personal health information for the purposes of treatment, payment, and internal operations. Initial: \_\_\_\_\_

Please list any individuals or parties for which you authorize the release of your personal health information: \_\_\_\_\_ Initial: \_\_\_\_\_

I have read/given opportunity to read the Southwind Physical Therapy Inc. "Notice of Privacy Practices". Initial: \_\_\_\_\_

I have reviewed Southwind Physical Therapy Inc. "Cancellation Policy". Initial: \_\_\_\_\_

**Financial Responsibility:** I hereby authorize payment of insurance benefits to Southwind Physical Therapy Inc. for services provided. This includes primary, secondary, governmental, and Medigap insurances. After insurance payment is received, any unpaid balance will be billed to patient or responsible party. Payment is expected within 30 days after billed unless other arrangements are made. I acknowledge I am ultimately responsible for financial accounts regardless of insurance coverage. Co-pays are due on date of service.

Courtesy Insurance Estimated: Co-Pay: \_\_\_\_\_ Deductible: \_\_\_\_\_ Co-Insurance (%): \_\_\_\_\_

Would you like to discuss a payment plan? Please circle Yes/No.

Southwind Staff Initial: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**As per Kansas Statute 65-2921**, please be advised...Physical Therapists make diagnoses for rehabilitation. Medical diagnoses are made only by Physicians of Healing Arts. Initial \_\_\_\_\_

How Were You Made Aware of Southwind Physical Therapy Inc.: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_