MINNESOTA SPORT & SPINE REHABILITATION

AUTHORIZATION FOR TREATMENT: I voluntarily consent to physical therapy care encompassing evaluation and treatment procedures. I acknowledge that no guarantees have been made to me about the results of the exam and/or treatment to be provided in this healthcare facility. I authorize Minnesota Sport & Spine Rehab (MSSR) to provide such treatment. **Initials** ___________

PAYMENT AUTHORIZATION: I request that payment be made on my behalf to MSSR for services furnished to me by MSSR . I authorize to release to the Centers for Medicare & Medicaid Services and its agents, any state Medicaid agency, and any other third party payor all medical or other information that is needed to determine the benefits payable for health services. I agree to pay the charges for the care and treatment rendered to me that are not covered by insurance including any reasonable collection fees required to collect delinquent accounts. **MY HEALTHCARE PROVIDER, INSURER, OR PLAN MAY REQUIRE A PHYSICIAN REFERRAL OR PRIOR AUTHORIZATION AND I MAY BE OBLIGATED FOR PARTIAL OR FULL PAYMENT FOR PHYSICAL THERAPY SERVICES RENDERED.** **Initials** ___________

RECORD RELEASE: I hereby authorize MSSR to release any/all medical information acquired in the course of treatment to myself, my insurance company, employer, QRC or other healthcare agencies, professionals, or persons who may provide healthcare services deemed necessary for continuing my medical care. **Initials** ___________

Please also release medical information regarding my physical therapy care to the following individual(s): (i.e., family members, coaches, trainers, etc.). It is not necessary to list physicians or insurance companies here.

Name	Relationship	Phone Number

HIPAA PRIVACY POLICY: I have been provided a copy of the HIPAA Privacy Policy for review and know that if I would like a copy of it to keep, I have requested one. **Initials** ___________

CANCEL/NO SHOW POLICY: I have read and understand MSSR's No Show Policy and know that if I would like a copy of it to keep, I have requested one.

Initials ___________

By signing below, I agree that I am responsible for the bill for any services rendered for myself or the patient for whom I am signing.

Patient's Printed Name: ____

_______________ ____

Date Signature of Patient or Patient Representative or Parent/Legal Guardian of Minor

If signed by patient representative or parent/legal guardian, indicate relationship to patient: ______________________

REQUIRED SIGNATURE (UPDATE ANNUALLY)

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MEDICARE PATIENTS ONLY: Are you currently receiving physical/speech/occupational therapy from a home health care agency, transitional care facility, or nursing home?: **Yes** o **No** o (If yes, we **cannot treat you today** as Medicare will not pay for our services while you receive any of the above).

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TPI Auth to Treat MSSR 3-22-12

14000 Nicollet Avenue • Suite 200 • Burnsville, MN 55337 Phone: 952-892-6777 Fax: 952-892-0792

MINNESOTA SPORT & SPINE REHABILITATION

CONSENT FOR TREATMENT OF MINORS

Minnesota Sport & Spine Rehabilitation requires that a parent or legal guardian accompany any minor children (under 18 years of age) to their medical appointments. In the event that a parent or legal guardian is unable to accompany a minor child to a medical appointment, the parent or legal must sign this Consent for Treatment of Minors to be kept on file at MN Sport & Spine Rehabilitation.

Name of child:____

Name of parent or legal guardian:____

Relationship to child:____

I authorize care and treatment for my unaccompanied child.

The following individual may authorize treatment for my child:

____ ________________________

I agree to reimburse MSSR for the cost of rendering services to my child in my absence.

________________ ____

Date Signature of parent or legal guardian