Lakewood Physical Therapy

Patient Name:_____ Date:_____

Please read the following information. Your signatures below apply only to your specific required authorization.

- **Consent for Treatment:** I hereby authorize the therapists at Lakewood Physical Therapy to perform the treatments or procedures approved by my referring physician. I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and/or procedures. I fully understand that it is impossible to make guarantees regarding the outcome of any medical treatment or procedure.

  Date:_____ X _____
  Signature of Patient or Authorized Person - Relationship

- **Assignment**: This is to certify that I (we) the undersigned hereby consent to and authorize the release of information necessary to settle my insurance claim, including worker's compensation. I authorize my insurance company to pay all therapy benefits directly to Lakewood Physical Therapy. I understand that I am personally financially responsible for all charges not covered by assignment.

  Date:_____ X _____
  Signature of Patient or Authorized Person - Relationship

- **Medicare Authorization and Lifetime Signature on File:** I request that payment of authorized Medicare benefits be made on my behalf to Lakewood Physical Therapy for any services furnished me by the provider I authorize any holder of medical, treatment, or supplies information about me be released to the Health Care Administration and its agents. This information will be used for the purpose of evaluating and administering claims of benefits.

  Date:_____ X _____
  Signature of Patient or Authorized Person - Relationship

- **Minor Consent:** This is to certify that I (we) the undersigned hereby consent to and authorize the release of medical information, including results of treatment to my parent or guardian.

  Date:_____ X _____
  Signature of Patient or Authorized Person - Relationship

- **Disclosure of Protected Health Information (PHI) to Family and Friends:** This is to certify that I, the undersigned, authorize Lakewood Physical Therapy to disclose Protected Health Information (PHI) to family members and friends. Please identify individual/s and relationship/s. (include spouse, grandparents, step-parents, etc):

  _____

  _____

  Disclosure of PHI to family and friends will be made in accordance with the procedures set forth by North Idaho Family Physicians LLC policy entitled "Policy Regarding Disclosure of Health Information to Family Members and Friends."

  Date:_____ X _____
  Signature of Patient or Authorized Person - Relationship