



_____ I give my consent to be treated at LSMPT. If I refuse to sign this consent and still obtain treatment from LSMPT consent is implied.

_____ I consent to have LSMPT bill my insurance for services rendered. I request payment of authorized benefits directly to the provider for services provided to me by LSMPT. I agree that any balance on my account will be my responsibility until my account is paid in full. Payment arrangements can be made if needed by contacting LSMPT. I agree to obtain any referrals and/or prior authorizations needed by my insurance carrier. If a necessary referral or prior authorization is not obtained I may be responsible for payment.

_____ I understand that LSMPT contacts my insurance carrier to inquire about outpatient physical therapy benefits **as a courtesy only**. Patients are ultimately responsible for knowing their own outpatient physical therapy benefits. Please contact your insurance carrier if you have any questions or concerns.

_____ I consent to the release of information about my medical condition to individuals involved in my care and for payment of my care.

_____ I acknowledge that I have been given a Notice of Privacy Practices for LSMPT. I recognize that outside of purposes for treatment, for payment, for certain healthcare operations or as permitted or required by law I must give my written authorization to LSMPT to release any of my protected healthcare information.

_____ I authorize the use of my medical records for medical or scientific research. By collecting information from medical records, researchers learn about new or better ways to diagnose and treat illnesses. Research results do not identify individuals by name or any other personally identifying characteristics. This authorization does not expire but may be revoked or limited in writing by me at any time.

_____ I understand that if I need to cancel an appointment I must call LSMPT at least 24 hours prior to my scheduled appointment or I may be charged a \$25 cancel / no show fee.

Patient or Guarantor Signature

Date