Assignment of Benefits

As a courtesy to the patients and their families, Valir Physical Therapy does submit a claim to many third party payers. I request that payment of authorized Medicare or private benefits be made to Valir Physical Therapy for any covered services furnished to me by Valir Physical Therapy. If my insurance carrier pays me directly, I agree to forward all funds to Valir Physical Therapy within 10 working days. I agree that I am responsible for paying all non-covered or unpaid amounts unless otherwise provide by law, regulation, or Valir Physical Therapy's contractual relationships. I agree to be responsible for the full amount of the charges from the date of delivery which my third party payer does not pay for in a timely manner, or if my physician or I fail to provide within ten (10) days the information necessary to submit the claim for payment.

Disclosure of Information

I understand that my medical records and billing information are made and retained by Valir Physical Therapy and are accessible to Valir Physical Therapy's personnel, who may use and disclose medical information for Valir Physical Therapy operations and functions and to any other health care personnel, involved in my continuum of care for this admission.

Release of Records

I authorize Valir Physical Therapy to release to any governmental health care program and its agents, or to any private insurance company or its agents any information needed to determine my benefits or the benefits payable for Valir Physical Therapy.

I hereby authorize my attending physician to release all medical records pertaining to my healthcare information to Valir Physical Therapy. I understand further, the information, authorized for release may include records which may have the presence of a communicable or venereal disease which may include, but is not limited to diseases such as Hepatitis, Syphilis, Gonorrhea and the Human Immunodeficiency Virus, also know as known as Acquired Immune Deficiency Syndrome (AIDS).

Acknowledgement of Notice of Privacy Practices

A complete description of how my medical information will be used and disclosed by Valir Physical Therapy has been given to me in Valir Physical Therapy's NOTICE OF PRIVACY PRACTICES. I have been given the opportunity and have been advised to read the notice prior to signing this Consent Form. If I have any questions, I know to contact the Compliance Officer whose information is provided to me in the Notice of Privacy Practices.

Consent for Care and Treatment

I, the undersigned, do hereby agree and give my consent for Valir to furnish medical care and treatment to the patient listed below that is considered necessary and proper in diagnosing or treating his/her physical and/or mental condition.

Patient Name | Date of Birth

Patient (or Parent/Guardian or Representative) | Date

Relationship to Patient

Witness | Date