

Petersen Injury Management Systems

Name: _____
 DOB: _____
 SS #: _____
 Address: _____

THIS FORM MAY NOT BE ALTERED

Acknowledgement of Receipt of Notice of Privacy Practices

English and Petersen Physical Therapy/Petersen Injury Management Systems reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the Notice of Privacy Practices for *Petersen Physical Therapy/Petersen Injury Management Systems*.

Patient Signature _____ **Date** _____

Patient Representative _____ **Date** _____

(Required if the patient is a minor or an adult who is unable to sign this form.)

Relationship of Representative to Patient _____

Release of/Request for Information Authorization

English and Petersen Physical Therapy/Petersen Injury Management Systems may disclose all or part of the patient's medical and/or financial records to your insurance carrier, to referring physicians, and to other healthcare providers responsible for providing continued patient care. We may request health information relating to your physical therapy.

Patient Signature _____ **Date** _____

Patient Representative _____ **Date** _____

(Required if the patient is a minor or an adult who is unable to sign this form.)

Relationship of Representative to Patient _____

Financial Agreement for Services Rendered

I acknowledge that *English and Petersen Physical Therapy/Petersen Injury Management Systems* is billing my insurance as a courtesy. I understand and agree that all services rendered are my responsibility. I authorize my insurance company to pay medical benefits directly to *English and Petersen Physical Therapy/Petersen Injury Management Systems* for services rendered to me and **I understand that the quoted insurance benefits are not a guarantee of payment.** I agree to pay as services are rendered for the estimated patient responsibility. I also agree to pay for items such as medical supplies as these generally are not covered by my insurance.

IT IS UNDERSTOOD THAT THE UNDERSIGNED AND THE PATIENT ARE PRIMARILY LIABLE FOR PAYMENT OF THE PATIENT'S BILL AND THEREFORE RESPONSIBLE FOR ANY AMOUNTS UNPAID BY THE INSURANCE COMPANY.

Please Note: *Petersen IMS* reserves the right to charge \$25.00 for missed appointments or appointments that are cancelled in less than 24 hours from your scheduled time.

Patient Signature _____ **Date** _____

Party Agreeing to Pay _____ **Date** _____

Relationship to Patient _____