

MARATHON

PHYSICAL THERAPY AND SPORTS MEDICINE

www.MarathonPhysicalTherapy.com

250 EAST MAIN STREET, NORTON, MA 02766 • 508-285-5533 • FAX 508-285-7977

Patient Authorization and Guarantee

RELEASE OF INFORMATION

I hereby authorize the release of any information by telephone or in writing, including reports of diagnosis, treatment, prognosis, recommendation, benefits payable, as well as any other data pertinent to my treatment, by Marathon Physical Therapy and Sports Medicine, LLC to my physician(s), as well as any organization responsible for payment of my account, and any legal representative involved in my litigation. I also authorize the release of information by telephone or in writing for utilization and quality review purposes.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize that the payment of authorized benefits be made directly to Marathon Physical Therapy and Sports Medicine, LLC for any services that are reimbursable by Medicare, Medicaid, or any third party sources.

VALUABLES

I hereby understand that Marathon Physical Therapy and Sports Medicine, LLC is not responsible for valuables and personal property brought to the facility.

CONSENT OF TREATMENT

I hereby consent to such treatment procedures and patient care which, in the judgment of the treating clinician, may be considered necessary or advisable while I am a patient of Marathon Physical Therapy and Sports Medicine, LLC.

GUARANTEE OF ACCOUNT

In consideration of services rendered to me by Marathon Physical Therapy and Sports Medicine, LLC, I hereby guarantee payment for any and all services rendered to me in which are not covered or allowable by insurance, together with collection costs, including reasonable attorney fees. I understand that there may be a charge for supplies that are needed during my course of treatment that will not be covered by my insurance and for which I am financially responsible. I also understand that I may have a co-payment, co-insurance and/or deductible which I am fully responsible for paying. Although Marathon Physical Therapy and Sports Medicine, LLC will inform me of my insurance coverage for physical therapy, it is ultimately my responsibility to understand my insurance benefit limitations and payments. I will immediately notify Marathon Physical Therapy and Sports Medicine, LLC of any changes in my insurance coverage while receiving physical therapy.

MEDICARE

I hereby certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any such information needed for this or related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I understand that I am responsible for any health insurance deductibles and co-insurance.

I, _____, by signing this document, acknowledge my consent to the above:
(Print Name)

Signature: _____

Date: _____