**IMPORTANT**
*******PLEASE READ THIS CAREFULLY*******
**McCabe & Brady Physical Therapy**

# *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 McCabe Physical Therapy, LLC, D/B/A McCabe and Brady Physical Therapy (MBPT), 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 any 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 MBPT for any services that are reimbursable by Medicare, Medicaid, or any third party sources.

**VALUABLES**
I hereby understand that MBPT are 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 my therapist and/or physician, may be considered necessary or advisable while I am a patient of MBPT.

**GUARANTEE OF ACCOUNT**
In consideration of services rendered to me by MBPT, 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 MBPT 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 MBPT of any changes in my insurance coverage while receiving physical therapy.

**CANCELLATION/NO-SHOW POLICY**
We require 24 hours notice in the event of a cancellation. Please have an alternative time in mind when you call to cancel so that you can receive your full amount of prescribed treatment. Many insurance carriers restrict your physical therapy benefit, so it is very important you take advantage of the available benefit. There is a $20 charge for a no-show or cancellation without proper notice. This charge will not be covered by your insurance. We take this policy seriously because when a patient misses an appointment, three people are hurt:

- The Patient – for not getting the treatment needed.
- The Therapist – who now has a hole in his/her schedule.
- Another Patient – who could have been scheduled at that time.

**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 a 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***:*** _____