PHYSICAL THERAPY
UNLIMITED, Inc.

Release of Medical Records: In order to ensure proper follow-up and continuity of care, I agree that a copy of my medical records (e.g. MRI reports, X-ray reports, etc) may be released to my physical therapist. I also agree, if necessary, that my health information may be shared with another health care provider for consultation purposes in respect to my care. I also agree that my information may be released to Precision Medical Services for billing purposes.

Insurance Authorization: I authorize release of any information concerning my (or my child's) healthcare and treatment provided for the purpose of administering claims for insurance benefits. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. I also hereby authorize payment of insurance benefits otherwise payable to me directly to Physical Therapy Unlimited, Inc.

Responsibility of Payment: Your insurance will be billed as a courtesy. If your insurance does not cover all of the visit charges, you are responsible for the remaining balance. All co-payments are due at time of services unless other arrangements have been made.

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Signature of patient or parent if minor Date

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