
## Patient Authorization Record

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| Authorization for Treatment<br>➢ I hereby give authorization for the performance of such rehabilitation procedures as permitted by New York State Statutes under the appropriate scope of practice are, in the judgment of my Therapist, deemed necessary. |
| Authorization for Release of Information<br>➢ I agree that Innova Physical Therapy may provide information from my medical record to persons involved in my medical care.<br>➢ I authorize the release of medical information necessary to obtain payment of any benefits available to me to Innova Physical Therapy for services rendered.<br>➢ I agree that Innova Physical Therapy may obtain information from others who have provided medical care to me and/or are responsible for the payment of all or part of my bills when this information is needed in order to treat, bill, and/or receive payment.<br>➢ I have read “Notice of Privacy Practices” mandated by HIPAA. |
| Authorization for Release of Payment<br>➢ I authorize that direct payment of any benefits available to me be released to Innova Physical Therapy for services rendered. |
| Cancellation or No-Show Fee<br>➢ I agree to pay a $50 fee if I do not contact Innova Physical Therapy within 24 hours of my scheduled appointment to cancel or reschedule. |
| Patient Agreement<br>➢ I agree to pay Innova Physical Therapy charges for services rendered to me during my course of treatment.<br>➢ I agree to pay those charges which may not be paid by my health insurance and are my responsibility per my insurance benefit. If I do not pay for charges that are my responsibility, I agree to pay Innova Physical Therapy *c*ollections costs including attorney and court fees. |

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Patient signature Date

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Printed patient name Witness Signature Date

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Signature of Legal Representative/POA