Hands On
PHYSICAL THERAPY

Authorization of Treatment:
Please sign on the line below

I hereby authorize Hands On Physical Therapy, LLC to render any and all therapy services or related services that the provider feels are needed and advisable to me in cooperation with the physician referral. I shall fully comply with all the requests of the provider in connection with therapy and all other treatment services.

All information given is true without any forgery to Hands On Physical Therapy, LLC. I understand that this authorizes the provider in connection with my treatment to any physician or insurance company to disclose information furnished or obtained by the provider.

Please read if applicable:

Auto Accidents: Hands On Physical Therapy, LLC will not file third party claims. You, the patient, must file through your auto insurance. You must file through your health insurance if medical pay has been exhausted. However, if your health insurance does not cover all expenses incurred due to deductible, or your health insurance investigates your claims and denies payment, you are responsible for the balance due. Our office will not do liens. Self-pay options are also available. If you file through your auto insurance, you must make a claim with your insurance agency and have a claim number available in order for claim to be processed.

Worker's Compensation: You must notify your employer and file a claim with them. You will not be seen if your employer has not been notified of this claim. If you believe/know your injury occurred at work and our office files claims with your health insurance, these claims may be denied. You will be responsible for the account balance.

Patient Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____

Witness Signature:_____ Date:_____