CONSENT FOR CARE & TREATMENT

I, undersigned, do hereby agree and give my consent for WRPT (Wind River Physical Therapy LLC) to furnish medical care and treatment to_____ that is considered necessary and proper in diagnosing or treating his/her physical condition.

_____ Responsible Party Initials/date

AUTHORIZATION BENEFIT ASSIGNMENT - FINANCIAL RESPONSIBILITY- RELEASE OF INFORMATION

I authorize Wind River Physical Therapy to release to the insurance carrier any information needed for the payment of any claim. I authorize payment to Physical Therapy and Sports Medicine Centers from my insurance carrier or third party payer. I agree to pay any applicable co-payments at the time of service and coinsurance and/or deductibles as agreed between Wind River Physical Therapy and me. I understand that my insurance benefits may not cover all charges and that I am responsible for those charges not covered by my health insurance or third party payer. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees. The above may not apply for those patients that are considered Worker's Compensation. However, be advised if your claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you. A photocopy of this authorization is to be considered as valid as the original. By my signature, I authorize Wind River Physical Therapy, to release all information necessary, including medical records, to secure payment.

_____ Responsible Party Initials/date

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I have had full opportunity to read the Wind River Physical Therapy's Notice of Privacy Practices. I understand that by signing this consent, I am giving my consent to Wind River Physical Therapy to use and disclose my protected health information to carry out treatment, payment activities and health care operations. I understand the terms of this notice may change with time and Wind River Physical Therapy will always post the current notice at the clinic, on the website and have copies available for distribution.

Indicated below are individuals whom Wind River Physical Therapy may speak to regarding my treatment. Please list names. □ spouse _____ □ father _____

□ mother _____ □ other _____

Listed below are individual(s) whom I request restriction regarding my protected health information. □ Not Applicable

□ _____

We may need to contact you. Do we have your permission to leave a confidential message at the phone numbers you provide us?

□ Yes: Home Mobile Work Other: _____ □ No

_____ Responsible Party Initials/date

SIGNATURE for CONSENT

By my signature below I acknowledge that I have read, understand and agree to the terms and conditions contained in the Consent for Care and Treatment, the Authorization to release all information necessary to secure payment and the Consent For Use and Disclosure of Health Information.

Patient / Guardian/Responsible Party Signature: _____ Date