AUTHORIZATION
AND
RELEASES

NOTICE OF PRIVACY PRACTICES

We will use and disclose your personal health information to assist in your treatment, to receive payment for the services we provide, and for routine healthcare operations. We have prepared a detailed "Notice of Privacy Practices" to help you understand our policies regarding your personal health information and your rights on how your medical information may be used and disclosed. A copy of this Notice is available to you or may be read on our website at www.firstchoiceptminot.com.

AUTHORIZATION FOR MEDICAL TREATMENT

I hereby authorize and consent to the rendering of such physical therapy or occupational therapy treatment considered to be necessary or advisable. Further, I realize that among those who attend to patients at First Choice Physical Therapy, Inc there are personnel in training who, unless requested otherwise, may be present during patient care as a part of their education.

FINANCIAL RESPONSIBILITY

I hereby authorize payment of any insurance benefits arising from policies insuring the patient, or any party liable to the patient, directly to First Choice Physical Therapy, Inc and the treating providers. I understand that I am financially responsible for any charges not covered by this assignment.

I hereby acknowledge that I have read each of the above statements and have received a satisfactory explanation of each item. As the patient (or authorized representative), I do agree and accept these terms.

____
Patient (or authorized representative) signature

____
Date

____
If authorized representative is signing, relationship to patient

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