



Patient Authorization

AUTHORIZATION FOR TREATMENT: I voluntarily consent to physical therapy care encompassing evaluation and treatment procedures. I acknowledge that no guarantees have been made to me about the results of the exam and/or treatment to be provided in this healthcare facility. I authorize OSI Physical Therapy to provide such treatment.

Initials _____

PAYMENT AUTHORIZATION: I request that payment be made on my behalf to OSI Physical Therapy for services furnished to me by OSI Physical Therapy. I authorize OSI Physical Therapy to release to the Centers for Medicare & Medicaid Services and its agents, any state Medicaid agency, and any other third party payor all medical or other information that is needed to determine the benefits payable for health services. I agree to pay the charges for the care and treatment rendered to me that are not covered by insurance including any reasonable collection fees required to collect delinquent accounts. **MY HEALTHCARE PROVIDER, INSURER, OR PLAN MAY REQUIRE A PHYSICIAN REFERRAL OR PRIOR AUTHORIZATION AND I MAY BE OBLIGATED FOR PARTIAL OR FULL PAYMENT FOR PHYSICAL OR OCCUPATIONAL THERAPY SERVICES RENDERED.**

Initials _____

RECORD RELEASE: I hereby authorize OSI Physical Therapy to release of any/all medical information acquired in the course of treatment to myself, my insurance company, employer, QRC or other healthcare agencies, professionals, or persons who may provide healthcare services deemed necessary for continuing my medical care.

Initials _____

PAYMENT AUTHORIZATION – PROMPT PAY: If you do not want your services billed to an insurance company, charges must be paid in full at the time of service in order to receive the discount. The amount charged is determined by the length of treatment as follows:

0-15 minutes	\$45.00
16-30 minutes	\$90.00
31-45 minutes	\$135.00
46-60 minutes	\$180.00

If a supply or pre-fabricated orthotic is issued, there will be an additional charge. I do not want my services billed to an insurance company, and will not do so myself.

Initials _____

OUT OF STATE REFERRAL OR SELF REFERRAL: I understand that if I have been referred by a physician who is not licensed in the state of MN and I am being treated at an OSI location in MN, I will be considered a Self-Referral and can be treated for 90 days. After that time, if I would like to continue treatment, I will need to obtain an order from a physician who is licensed in the state of MN. The same 90 day rule pertains if I have not been referred by a physician and I am self-referring.

Initials _____

RECORD RELEASE FOR ATHLETES: I hereby authorize OSI Physical Therapy to release any relevant information regarding my/my child's injury status to my/my child's current athletic coach.

Initials _____

By signing below, I agree that I am responsible for the bill for any services rendered for myself or the patient I am signing for.

Patient's Printed Name: _____

Date _____ Signature of Patient or Patient Representative or Parent/Legal Guardian of Minor

If signed by patient representative or parent/legal guardian, indicate relationship to patient: _____

REQUIRED SIGNATURE (UPDATE ANNUALLY)

REVISED 03/22/10

Initial only if applicable