PATIENTS NAME

# C.O.A.S.T. PHYSICAL THERAPY SERVICES

## AUTHORIZATION FORM FOR USE & DISCLOSURE OF HEALTH INFORMATION

**To All New and Established Patients:**

**COAST Physical Therapy Services is required by law to maintain the privacy of our patient's health information. Unless you have signed a form authorizing the use or disclosure, we will not use or disclose your health information for any purpose other than COAST's role in treatment, payment or for health information. With your written approval, we may disclose your health information to others including designated family, friends, or others who are involved in your health care or in payment for your health care. This form allows you to designate this/these person(s). A copy of this form is as valid as the original.**

**I,_____, hereby authorize the use or disclosure of health information about me as described below. As the parent/guardian, I authorize the use or disclosure of health information about my minor dependent.**

**Dependents Full Name** **Date of Birth**

1. **Person or group authorized to disclose information:**

   **COAST Physical Therapy Services**

2. **Person or group authorized to receive and use information from COAST Physical Therapy Services**

   **Current Insurance Provider(s)**

   **Spouse** _____

   _____

   **Family/Friends**_____

   _____

   **(Please provide name, address and relationship)**

**(SIGN THE BACK)**

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**Continued:**

3. **Description of the information that may be used or disclosed:**

   **All health information pertaining to me or my minor dependent. If applicable, related to diagnosis, treatment or prognosis with respect to any physical, accident, illness, medical condition and any other plan related information.**

4. **I understand that if the person or entity that received the information described herein is not a health care provider or health plan covered by federal privacy regulation, the information described here may be re-disclosed to such person or entity and will likely no longer be protected by federal privacy regulations.**

5. **If the person completing this authorization is the personal representative of the member/patient or dependent, describe your authority to act on this persons behalf.**

   _____

6. **I understand that I am not required to sign this authorization form and that COAST Physical Therapy Services will not refuse or discontinue treatment to me by not signing.**

7. **I understand that I may revoke this authorization in writing at any time, except to the extend that action has been taken by COAST in reliance on this authorization by sending a written signed and dated revocation to COAST.**

8. **I understand that either I or my personal representative, may receive a copy of this authorization upon request and that I may inspect or copy the information to be used or disclosed.**

_____

**Member/Patient Signature** **Today's Date**

_____

**Personal Representative Name**

_____

**Personal Representative Printed Name**

PATIENTS NAME

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## Cancellation Notice

**To All New and Established Patients:**

**Patients not calling (24 Hour Notice) or showing for your scheduled appointment may result in a $45 fee.**

**This fee will be collected on the next scheduled appointment. It must by paid with cash, check or credit card.**

**Insurance will not pay for this fee.**

**Patient/Parents Signature** **Today's Date**

PATIENTS NAME

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## HIPAA Patient Acknowledgment

**I acknowledge that I have received a copy of the Notice of Privacy Practices of COAST Physical Therapy Services.**

**I further acknowledge that a copy of the current notice is posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at my next appointment.**

**Patient/Parents Signature** **Today's Date**

PATIENTS NAME

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## Insurance/Billing Payment Agreement

**To All New and Established Patients:**

**Providing you have medical insurance benefits and you elect to use those benefits for services rendered, COAST Physical Therapy Services will submit your claims to your insurance company and payment will be assigned to COAST.**

**It is important that you can contact your insurance company benefits department DIRECTLY and obtain specific limits, benefits, deductibles/copayments or any other information regarding your rehabilitation or physical therapy treatments.**

**You are solely responsible for all charges incurred and we will expect payment for denied, non-covered and patient responsibility amounts as directed by your coverage.**

**Patient/Parents Signature** **Today's Date**