Consent for Treatment – Assignment of Benefits – Authorization to Pay – Information Release

To Central Missouri Physical Therapy and Hand Rehabilitation: You are authorized to provide any independent claim administrators and consulting health professionals and utilization review organization information concerning healthcare, advise, treatment or supplies provided to Patient. This information will be used for the purpose of evaluating and administrating claims for benefit. I also authorize payment of Medical Benefits to Central Missouri Physical Therapy and Hand Rehabilitation for service. I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

The following documents have been given or made available to me:

1. Summary notices of privacy practices
2. Non-discrimination policy
3. Statement of privacy rights

I, the undersigned, agree and give my consent for Central Missouri Physical Therapy & Hand Rehabilitation to provide evaluation and treatment to ________________________ considered necessary and appropriate in assessing or treating his/her physical condition. Additionally I authorize my insurance benefits to be paid directly to Central Missouri Physical Therapy & Hand Rehabilitation and I am financially responsible for non-covered services. I also authorize Central Missouri Physical Therapy & Hand Rehabilitation to release any information to process this claim.

Patient or Authorized Person's

Signature: ____________________________________ Date: _____________________