



**GENERAL CONSENT & ASSIGNMENT OF BENEFITS**

**AUTHORIZATION FOR TREATMENT:**

I hereby authorize **College Park Physical Therapy** to provide such medical care and to administer such treatment necessary to the named patient or me each time I, or the named patient, present to outpatient physical therapy. Such procedures and treatments may include Physical Therapy and Occupational Therapy.

I acknowledge that no guarantee or assurances have been made to me concerning the results intended from my treatment.

Patient Initials: \_\_\_\_\_

**Consent for Photographing or Other Recording for Security and/or Health Care Operations**

I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

YES                       NO

Patient Initials: \_\_\_\_\_

**Consent to Email, Cellular Phone, or Text Usage for Appointment Reminders and Other Healthcare Communications**

We want to stay connected with our patients. Patients in our practice may be contacted via email, calls to your cellular telephone (including prerecorded/artificial voice messages and /or calls from an automatic dialing device), and/or text messaging to confirm an appointment, to obtain feedback on your experience with our healthcare team, and to be provided general health reminders/information.

If at any time you provide an email, cellular telephone number, address or text number, you understand that that you may get these communications from the Practice. You may opt out of these communications at any time by notifying the office, in writing. Please note, standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Patient Initials: \_\_\_\_\_

**ASSIGNMENT OF BENEFITS:**

I assign to College Park Physical Therapy, all of my benefits and rights under any insurance contracts for payment of services rendered to me by College Park Physical Therapy. I authorize all information regarding my benefits under any insurance policy related to any claim to be released to College Park Physical Therapy; I authorize College Park Physical Therapy to file insurance claims on my behalf for services rendered to me. I direct that all such payments go directly to College Park Physical Therapy. I authorize College Park Physical Therapy to act on my behalf and report any suspected violations of proper claims practice to the proper regulatory authorities.

I authorize College Park Physical Therapy to obtain counsel and enter into legal or other action on my behalf and/or in my name, including the arbitration/dispute resolution process, to collect such sums due, should the sums not be paid within the legally prescribed time frame.

I fully understand that I am directly and fully responsible to College Park Physical Therapy for all medical bills submitted by them for services rendered to me, and, I agree to pay the same, and that this assignment is made solely for College Park Physical Therapy's additional protection. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover.

This assignment is irrevocable unless: (1) I and College Park Physical Therapy, in writing, terminate this assignment, and (2) College Park Physical Therapy is fully paid for all services relating to my care.

A photocopy of this assignment shall be as valid as the original. The assignment of benefits has been explained to my full satisfaction and I understand its nature and effect.

Patient Initials: \_\_\_\_\_

**I confirm that I have read and fully understand the above.**

Facility Name: **College Park Physical Therapy**

\_\_\_\_\_  
Patient PRINTED Name

\_\_\_\_\_  
Parent/Guardian PRINTED Name (if minor patient)

\_\_\_\_\_  
Patient SIGNATURE Name (Parent/Guardian Signature if Minor)

\_\_\_\_\_  
Date