Success Physical Therapy and Balance Center

2842 West Sepulveda Blvd
Torrance, California 90505
(310) 325-0800

1. CONSENT FOR TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION TO INSURANCE CARRIER. ***A copy of this is valid as the original***

I, the undersigned, do hereby agree and give my consent for Success Physical Therapy to furnish medical care and treatment considered necessary and proper in the diagnosis and treatment of my physical condition.

2. ASSIGNMENT OF BENEFITS

I request that payment of authorized **Medicare** and **Supplemental Insurance** benefits be made on my behalf to Success Physical Therapy for any services furnished to me by that provider. I authorize any custodian of medical information to release to the Health Care Financing Administration and its agents information needed to determine benefits payable for related services. I understand that I am financially responsible for any balance not covered by my insurance carrier.

3. CONSENT TO SHARE MEDICAL AND/OR BILLING INFORMATION

In the event that our office staff may need to discuss medical or billing issues with you or your family, please provide the name(s) of those with whom we may speak. This will allow us to maintain your privacy.

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4. I acknowledge that I have received a copy of Success Physical Therapy's Notice of Privacy Practices.

I acknowledge that I have read and understand the above information.

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Signature Relationship to Patient Date

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Signature of Witness Date