Success Physical Therapy, Inc.
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, Inc. to furnish medical care and treatment considered necessary and proper in the diagnosis and treatment of my physical condition. I will be given opportunity to ask questions and to have them answered to my satisfaction. I understand that I may decline treatment at any time. Permission is granted to release information to my insurance company, workers compensation carrier, physician/facility referred to further treatment, and/or my referring physician. Permission is hereby granted to release medical records to Success Physical Therapy, Inc.

2. ASSIGNMENT OF BENEFITS

I hereby authorize release of medical information necessary to file a claim with my insurance company (PPO, POS, HMO, WORKERS COMPENSATION, THIRD PARTY PAYOR) and assign benefits otherwise payable to me to Success Physical Therapy, Inc. All payments received will be applied to my balance. I will be responsible for co-pays/co-insurance and deductibles that may apply. Although Success Physical Therapy, Inc. will help verify and assist me in understanding my benefits, it is ultimately my responsibility, and I will not hold Success Physical Therapy, Inc. responsible for any misinterpretation of insurance benefits. I understand that any charges not paid by insurance company are my responsibility and payable by me.

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, Inc'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

(Expires in one year from date)

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Signature of Witness | Date