3507 Post Street Clinton, NY 13323
315.557.6848
megamotionpt@gmail.com

PATIENT STATEMENT

To the best of your knowledge, did the injury for which we are treating you give rise to a claim (Auto/No Fault/Motor Vehicular accident or Workers Compensation Case) against another individual or their insurance company? YES_____ NO_____ If YES , STOP and consult with Megamotion Physical Therapy staff before continuing. _____ (Initial/ Signature). Personal Responsibility for Charges: I understand that I am personally responsible for charges and/or balances not covered by insurance payments or settlements.

HIPAA AUTHORIZATION FORM

I, _____, give permission to Megamotion Physical Therapy to use the following protected health information, and/or disclose the following protected health information: Medical Records, Treatment Records, Diagnostic Records and other pertinent documents to render healthcare service. This protected health information is being used/or disclosed for the following purposes: treatment, payment, and healthcare operations. This authorization expires upon written request of this patient. If the person or entity receiving this information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits. You may inspect or copy the protected health information to be used or disclosed under this authorization. For protected health information created as part of a clinical trial, your right to access is suspected until the clinical trial is completed. Finally, you may revoke this authorization in writing at any time by sending written notification to Jeorge U. Arcellana, PT at 3507 Post St. Clinton, NY 13323. Your notice will not apply to actions taken by the requesting person/entity prior to the date they received your written request to revoke authorization. Megamotion Physical Therapy does not sell, rent, share, or disclose personal information to third parties without your prior consent.

CONSENT FORM

I irrevocably assign to Megamotion Physical Therapy ("The Provider"), all my rights and benefits, under any insurance contracts, for payments of services rendered to me and I agree to pay for all portions of services due in full at the services are rendered by the provider. The provider accept cash, personal checks, credit card, and patient financing options for credit worthy patients. Returned checks are assessed a $25.00 NSK charge. If not paid according to terms, I understand that the provider may report to an outside collection agency and attorneys fee are added to the collectible debt balance. I irrevocably authorize the provider to act on my behalf and report any suspected violations of improper claim practices to the proper regulatory authorities. This assignment of benefits has been explained to my full satisfaction and I understand its nature and effect.

Patient Signature: _____ Date:_____