GPPT – AUTHORIZATION FORM

Name of Beneficiary_____ **Insurance ID #** _____

Medicare

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the name of provider of service and (or) supplier for any services furnished to me by that provider of service and (or) supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related service.

Signature_____ Date_____

All Insurance Carriers

I authorize that payment on my behalf be made directly to Greater Pittsburgh Physical Therapy and Sports Medicine (GPPT) for all covered charges and any services NOT paid by me. I agree to pay GPPT for all charges that are not covered or are denied by the applicable insurance carrier. This agreement pertains to coverage by all private, managed care, auto, government and workers' compensation insurance carriers.

GPPT request that you make payment or payment arrangements within 30 days.

Signature_____ Date_____

Record Release Authorization

I authorize Greater Pittsburgh Physical Therapy and Sports Medicine and its agents to release routine information pertaining to my evaluation and treatment to their agents, my employer, workers' compensation insurance carriers, referral source, primary care physician, a consulting physician or medical facility, spouse, immediate family members or guardian, or myself to aid in my medical management.

Signature_____ Date_____

The above-signed authorizations are to be considered valid as long as I am under the care of Greater Pittsburgh Physical Therapy and Sports Medicine unless revoked by written request.

HIPAA

Acknowledgement of receipt of Greater Pittsburgh Physical Therapy and Sports Medicine Notice of Privacy Practices:
Please sign and print your name and date this acknowledgement form.

Signature_____ Date_____