AUTHORIZATION FOR OCCUPATIONAL THERAPY AND RELEASE OF INFORMATION

Name:_____ Date of Birth_____

I authorize _____ to perform Occupational Therapy Services
Company
consisting of but not limited to the evaluation(s), screening(s), treatment(s), and/or consultation(s) as necessary. I authorize the company to act on my behalf to obtain payment from my insurance company(s). Any balance remaining following reimbursement received from an insurance company(s) will be billed directly to the responsible party. This may include, but is not limited to: services billed to a non-participating insurance company, an absence of insurance coverage and/or services completed that were not reimbursable by insurance company.

PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, ASSIGNMENT OF BENEFITS, AND PAYMENT REQUEST

- I certify that the information given by me in applying for payment, under Title XVIII of the Social Security Act, is accurate.
- I hereby authorize the above provider to release medical information and necessary data pertinent to the filing of insurance papers in the interest of the patient and/or provider. I authorize any holder of medical or other information regarding this patient, to release to Centers of Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or benefits payable for related services.
- I authorize that payment of authorized Medicare benefits and/or other health insurance company benefits be made on my behalf to the company for any services furnished by the company or its affiliates.

AUTHORIZATION TO APPEAL

I hereby authorize the above provider to appeal any services denied by Medicare and Medicaid and any third party insurance on my behalf.

CONSENT OF DISCLOSURE

I hereby give consent to the company and all health care providers furnishing care within the company to use and disclose my protected health information for the purpose of treatment, payment and health care operations. I understand that this consent can be cancelled at any time. My cancellation must be in writing, signed by myself, or signed on my behalf, and delivered to the address above. It will become effective the day of its receipt. I have the right to request restrictions on the usage and disclosure of my protected health information for the purposes of treatment, payment or health care operations. The company is not required to grant my request, however, if the company does, the restriction will be obligatory to the company. Our posted Privacy Policy provides more detailed information about the usage and disclosure of your protected health information. You have the right to review our Posted Privacy Policy. You may obtain a copy of the current policy by asking any representation of the company.

I authorize the company to RELEASE OR OBTAIN information pertaining to my therapy from all appropriate health care providers.

Patient/Legal Power of Attorney Signature	Date	Witness (if patient signature is not legible)	Date

Power of Attorney_____ (Please print) Witness_____(Please print)

If verbal consent obtained please enter below:
Date Obtained:_____ From Whom Obtained:_____(Please print)

Fax No. that POA agreed to return signed form _____
(Enter Number)

Date agreed form would be received _____