Patient Name: ______________________

TIDEWATER PHYSICAL THERAPY/ELECTROMYOGRAPHY

CONSENT FOR TREATMENT: I, the undersigned, knowing that I am suffering from a condition requiring health care, do hereby voluntarily consent to evaluation of and treatment for my condition by the therapists of Tidewater Physical Therapy and Rehabilitation Associates, P.A. / Tidewater Electromyography (EMG).

RELEASE AND ASSIGNMENT OF BENEFITS: I authorize the release of my medical records and all my medical information held by Tidewater Physical Therapy from any source (unless redisclosure is restricted) to all persons involved in my treatment, payment for my treatment or health care operations of Tidewater Physical Therapy. I also authorize Tidewater Physical Therapy/EMG to submit insurance carrier claim forms on my behalf without further signature authorization. This also authorizes Tidewater Physical Therapy/EMG to receive payment directly from the insurance carrier. All claim forms will be submitted to the carrier with the notation "Signature on File". In addition, this authorization and consent further authorizes any party involved in the processing of my claim to release any and all information, without limitation, to Tidewater Physical Therapy.

DISCLOSURE: We must emphasize that as health care providers, our relationship is with you, not the insurance company, your employer or attorney. As a courtesy to our patients, we will bill your insurance company for you and allow them thirty days to process our claim. We ask that you assist us by working with your insurance company to have our bill processed. In cases of Workers Compensation or Auto Accident, should your benefits exhaust or become denied, your private health insurance will be billed. You will be expected to pay all applicable copays, coinsurances and deductibles. A statement will be sent to you for full payment, since you are the ultimate responsible party.

If your account becomes past due and is placed with a collection agency, all collection fees will be added to your balance. Fees include the collection agency's commission, ranging from 28-40% of the balance, court costs and interest accrued.

I UNDERSTAND AND AGREE TO THE ABOVE CONSENT FOR TREATMENT, RELEASE AND ASSIGNMENT OF BENEFITS, DISCLOSURE AND POLICIES AS THEY PERTAIN TO ME.

This consent to release of medical information shall be valid for one year. I understand that I may revoke this consent at any time.

______________________________ ___________ ______________________________

(Signature) SEAL (Date) (Witness)
(or Parent's Signature if Minor)