Diane Ryan, P.T. Physical Therapy Patient Insurance Authorization Statement

Thank you for choosing Diane Ryan, P.T. Physical Therapy for your rehabilitation. We do not bill insurance companies and you are expected to pay your bill in full at the start of each visit. Payment may be made by cash or check. We will provide a receipt with physical therapy codes that you may submit to your insurance company. Diane is out of network with all insurance plans therefore your reimbursement will most likely be at the insurance company's out of network rates.

If you have any questions, please speak to a staff member.

I have read and agree to all policies. I authorize the release of any medical information to the insurance company necessary to pay the claim.

_____ _____ _____

Patient/Responsible Party (print) Signature Date

Diane Ryan., P.T. Physical Therapy Consent and HIPPA Privacy Form

Parental Consent Form

Patient Name:_____

I am aware that my child is receiving Physical Therapy with Diane Ryan, P.T. Please accept this form as my consent to treat my child.

_____ _____ _____

Patient/Responsible Party (Print) Signature Date

Consent for Care and Treatment

I, _____, authorize Diane Ryan, P.T. to furnish medical care and treatment that is considered necessary and proper in the diagnosing and treating of my physical condition. I understand that this authorization shall be valid until I revoke the agreement through written notice to Diane Ryan, P.T.

Name_____Signature_____Date_____

HIPPA Privacy Statement

With my permission, Diane Ryan, P.T. may use and disclose my protected health information (PHI) to carry out treatment, payment, and healthcare operations (TPO). You have the right to inspect, copy, and amend your PHI. You have the right to request restrictions on the use of your PHI. You have a right to an accounting of the disclosures of our PHI for other than TPO.

With my permission, the office of Diane Ryan, P.T. may call my home or other designated numbers to leave a message on voicemail or in person, or mail or email in reference to carrying out TPO such as appointment reminders, insurance information, call pertaining to clinical care and test results.

HIPPA Compliance Authorization for Disclosure and Use of Medical Information

I hereby authorize my Primary Care Physician or other specialist to release to Diane Ryan, P.T. medical information such as lab reports, X-ray and MRI reports and all related medical information as appropriate to assist with my diagnosis and physical therapy treatment.

We may need to communicate with your physicians concerning your treatment. Please advise us in writing if you do not wish us to communicate with your physician.

I hereby authorize Diane Ryan, P.T. to disclose my medical records to my insurance company for the purpose of assisting in the settlement of my insurance claims for Physical Therapy.

_____ _____ _____

Patient/Responsible Party Signature Date