

*Patient Registration*

**BACK TO ACTION  
PHYSICAL THERAPY  
PLC**

*Waitsfield Vermont*

**PATIENT AUTHORIZATION FORM**

**Acknowledgement of Notice of Privacy Practices**

I, \_\_\_\_\_, have reviewed and been offered a  
(Patient's Name)  
copy of the Back To Action Physical Therapy, PLC Notice of Privacy Practices. Back To Action Physical Therapy is required to give me a copy of this notice by the Federal HIPAA (Health Insurance Portability and Accountability Act) Law.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(Parent or Guardian if patient is under 18)

**Payment Authorization**

Payment of medical benefits may be made on my behalf to Back To Action Physical Therapy, PLC for any services furnished to me by the provider. **I understand that in accepting medical services, I am also accepting responsibility for the payment for those services.** I agree to pay for any and all costs for which my insurance company denies payment. Should the balance of the account exceed an amount the undersigned is able to pay in full, an agreed payment plan can be established by speaking with the Billing Manager.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(Parent or Guardian if patient is under 18)

**Release of Medical Information Authorization**

I authorize Back To Action Physical Therapy, PLC to release my medical and other information to my insurance company, as stated in my policy. I also authorize release of medical and other information to any other medical professional, when appropriate.

I also authorize Back To Action PT to discuss my care with or provide information to the following persons. Please include any family members you wish us to be able to speak with regarding your care.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(Parent or Guardian if patient is under 18)