

PATIENT INFORMATION:

Stratford Therapy Services, Inc.

Date: ___/___/___ Patient Name (please print): _____

Responsible Party (if a minor): _____ Relationship to Patient: _____

I authorize Stratford Therapy Services, Inc. to call and leave a message at the following numbers:

Home phone: _____ Cell Phone: _____ Work Phone: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Birthdate: ___/___/___ Sex: F M Age: _____ Social Security #: _____

Patient employed by: _____ Occupation: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Is this work related? Yes No

*In case of emergency, who should be notified? _____ Phone Number: _____

CONSENT FOR TREATMENT AND PAYMENT:

I understand that I have been recommended for Physical/Occupational Therapy. I also understand that I will be evaluated and treated by a licensed therapist and I authorize this treatment. I understand there is no guarantee of results. I further agree that I will be responsible for any expenses incurred not covered by any third party payer (such as Medicaid, Medicare or other Insurance Company). I understand that if at any time I allow a third party to accompany me into a treatment room, I release Stratford Therapy Services Inc. from any disclosures that may occur. I have received a copy of Stratford Therapy Services, Inc.'s Notice of Privacy Practices with an effective date 09/01/02.

Signature of Patient

Responsible Party (if other than patient)

Witness

Date

ASSIGNMENT OF INSURANCE BENEFITS:

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes Stratford Therapy Services, Inc. to submit claims for benefits, services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I hereby authorize according to the policy I have provided _____ and _____
Primary Insurance **Secondary Insurance (if any)**

to pay and hereby assign directly to Stratford Therapy Services, Inc. all benefits, if any, otherwise payable to me for services as described on the billing forms.

I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Stratford Therapy Services, Inc. will be credited to my account in accordance with the above said assignment.

Authorized Signature of Subscriber

Date

MEDICARE AUTHORIZATION (if applicable):

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Stratford Therapy Services, Inc. for any services furnished to me. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (formerly known as the Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits payable for related services. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved billing forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, Stratford Therapy Services, Inc. agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible and coinsurance. Coinsurance and the deductible are based upon the charge determined by the Medicare carrier.

Signature

Date