CHUGACH
PHYSICAL THERAPY
2740 Lake Otis Pkwy, Anchorage, AK 99508
Phone: 907-743-3333, Fax: 907-272-8164

# Conditions of Admission and Authorization for Treatment

## Please Read Before Signing

**1. Consent to Therapy Services**
I, the undersigned, consent to the procedures during outpatient treatment which may include, but are not limited to, evaluation, therapeutic exercise, soft tissue mobilization, joint mobilization, ultrasound, phonophoresis, electric stimulation, traction, education, water therapy and modalities. _____**initial**

**2. Cancelation and No-Show policy**
I have read and understand the Cancellation and No-Show policy and agree to comply. _____**initial**

**3. Notice of Privacy Practices**
I acknowledge that I have been provided the opportunity to review CPT's Notice of Privacy Practices. I understand that if I have questions or comments I may contact CPT's management. _____**initial**

**4. Financial Agreement**
I, the undersigned, agree, whether I sign as parent, guardian, spouse, agent, guarantor, or as patient, that in consideration of the services to be rendered to the patient, I hereby individually obligate myself to pay the account of CPT in accordance with the regular rates and terms of CPT. Should the account be referred to an attorney or collection agency, I shall pay actual attorney's fees and collection expenses. All delinquent accounts shall bear interest at the legal rate. _____**initial**

**5. Assignment of Benefits**
This assignment of benefits allows CPT to be paid directly by my health insurance carrier or other health benefit plan for the services CPT provides to me, my minor child, or other person entitled to health care benefits. In return for services rendered by CPT, I hereby irrevocably assign and transfer to CPT all rights, title, and interest in all benefits payable for the healthcare rendered, which are provided in any and all insurance policies and health benefit plans from which my dependents or I are entitled to recover. This assignment and transfer shall be for the purpose of granting CPT an independent right of recovery against my insurer or health benefit plan, but shall not be construed as an obligation of CPT to pursue any such right of recovery. In no such event will CPT retain benefits in excess of the amount owed to CPT rendered during this admission. I have read and been given the opportunity to ask questions about this assignment of benefits, and I have signed this document freely and without inducement, other than the rendition of services by CPT. _____**initial**

**6. Release of Information**
I acknowledge that CPT will use my information for the purposes of treatment, payment and health care operations.

I authorize CPT to release medical information and supporting documentation in my medical records to any organization, or guarantor which is or may be responsible for payment of charges associated with my care and for all other purposes of benefit payment. If my injury is work-related, I authorize CPT to release any information from my medical records to my employer and/or its designee.

I acknowledge that patient medical records at CPT may be stored electronically and made available through computer networks available to CPT personnel, physicians involved in my care and their offices. I also acknowledge that should I be treated at another facility in the area affiliated with CPT, my medical records may be made electronically available to the other facility, physicians involved in my care and their offices. This will assist my therapist and other caregivers in reviewing past treatment as it may affect my condition and treatment at that time.

I authorize CPT or its authorized representatives to contact me by telephone, e-mail, or U.S. mail during my treatment period and after my discharge from therapy.

I authorize the release of my social security number in accordance with federal law and regulations to the manufacturer of any medical device I may receive.

**I hereby certify and state that I have read, and that I fully and completely understand this Conditions of Admission and Authorization for Medical Treatment, and that I have signed this document knowingly, freely, and voluntarily. Moreover, I certify and state that I have received no promises, assurances, or guarantees from anyone as to the results that may be obtained by any medical treatment or services.**

**X**_____ _____ _____
Patient/Parent/Guardian/Conservator/Domestic Partner Date Time

_____ **X**_____
If other than patient, indicate relationship CPT Witness to Signature only