AOSPT
Rehabilitation Services
Licensed Physical Therapists, Occupational Therapists & Speech Language Pathologists

CONSENT FOR OUTPATIENT SERVICES
AUTHORIZATION TO PAY INSURANCE BENEFITS AND RELEASE MEDICAL INFORMATION

I, the undersigned, does hereby voluntarily consent to evaluation and/or treatment, and I authorize whomever he/she may designate, including physician(s), therapist(s), etc. to direct or administer such treatments as therapeutically necessary.

I acknowledge that because medicine is not an exact science, no guarantees or warranties can be made regarding the results of any treatment in this facility.

I have been informed of my rights and responsibilities as a patient.

The Atlantic Orthopedic and Sports Physical Therapy/Mid-Atlantic Privacy Notice may be obtained upon request.

I hereby authorize payment directly to:

Atlantic Orthopedic and Sports Physical Therapy
129 North White Horse Pike
Hammonton, NJ 08037

Mid-Atlantic
129 North White Horse Pike
Hammonton, NJ 08037

For the medical expense benefits otherwise payable to me; but not to exceed the providers' regular charges, this is a direct assignment of my rights and benefits under this policy.

I understand that it is my responsibility for charges not covered by my insurance and I agree to pay all balances remaining after my insurance has made payment.

A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize Atlantic Orthopedic and Sports Physical Therapy/Mid-Atlantic to appeal any utilization management determined by my insurance company resulting in a denial, termination, or limitation of covered health care services in accordance with the provisions of New Jersey stature N.J.A.C. 8:38-8.5 through 8.7 or to initiate a complaint to the Insurance Commissioner for the any reason on my behalf.

By signing this form I certify that I fully understand the above statements.

_____
Signature of Witness Date

_____
Signature of Patient Date

_____
Signature of Nearest Relative/Guardian

_____
Relationship to Patient