

## PATIENT AUTHORIZATION

Welcome and thank you for choosing GSPORTS Physical Therapy! So that we may provide you with the best physical therapy care possible, please read and initial next to each paragraph below.

**Release of Information & Consent to Treatment**

\_\_\_\_\_  
Initials

I attest to the fact that all information herein is true and correct. I am aware of my diagnosis and wish to receive treatment at G Sports Physical Therapy, Inc., its subsidiary, and/or affiliate. I permit its employees and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care can include an evaluation, testing, and treatment. No guarantees have been made to me about the outcome of this care. I give permission to G Sports Physical Therapy, Inc., its subsidiaries, and/or its affiliates to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment or payment for services provided. I authorize G Sports Physical Therapy, Inc., its subsidiaries, and/or its affiliates to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.

**Assignment of Benefits**

\_\_\_\_\_  
Initials

I authorize payment directly to G Sports Physical Therapy, Inc., its subsidiaries, and/or affiliates for services and to bill and release payment directly to G Sports Physical Therapy, Inc., its subsidiaries, and/or affiliates for any physical therapy, personal training, massage, and wellness services provided. This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original.

**Notice of Privacy Practices (HIPAA Acknowledgment/Consent)**

\_\_\_\_\_  
Initials

I hereby acknowledge that I am aware of The Notice of Privacy Practices for G Sports Physical Therapy, Inc., its subsidiaries, and/or affiliates. In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and health care operations. See front desk if you require more information.

**Appointment Reminders**

\_\_\_\_\_  
Initials

I hereby acknowledge that I am responsible for adhering to the Attendance Policy independent of any appointment reminders. Appointment reminders sent by G Sports Physical Therapy, Inc. are a courtesy and **should not** be relied upon to properly adhere to the Attendance Policy. I understand that the email, text, and/or phone appointment reminders are **not guaranteed** to be sent 24 hours in advance of my scheduled appointments.

**The signature below certifies that I have read and understand the above information.**

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Name Printed

\_\_\_\_\_  
Parent or Guardian Name Printed