\*Initial in each box for each separate authorization:

|  |  |
| --- | --- |
|  | Authorization for Treatment:* I consent to examination, treatment, and the administration of such procedures as may be considered necessary or advisable by my therapist at Active Solutions.
 |
|  | Authorization to Treat Minor:* I hereby give Active Solutions Therapy authorization to treat minor children in the absence of the parent or legal guardian.
 |
|   | Authorization for Release of Information:* I hereby authorize Active Solutions Therapy to release my medical records to any healthcare provider from whom I have obtained or will obtain healthcare services, or to any insurance company, payer, person, or entity whom may also be responsible (in addition to myself) for payment for services I receive.
 |
|  | Authorization for Release of Payment:* I authorize that direct payment of any benefits available to me be release to Active Solutions Therapy for services rendered. I have verified that I have informed Active Solutions Therapy Services that I have \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ as my primary insurance and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ as my secondary insurance company.
 |
|  | Medicare and/or Medicaid:* I agree that the information given to Active Solutions Therapy in applying for benefits under Medicare and/or Medicaid is complete and accurate. I agree that Active Solutions Therapy Services may give Social Security Administration or its fiscal intermediary’s information necessary to process claims.
 |
|  | Workers Compensation:* I agree that the information given to Active Solutions Therapy in applying for benefits under workers Compensation is complete and accurate. I agree that Active Solutions Therapy Services may be given intermediary’s information necessary to process claims.
 |

x\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_x\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Patient signature DOB

x\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_x\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Patient Printed Name Date

x\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_x\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Employee Witness Signature Date