\*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