

Scientific Therapy Policies and Procedures

Medical Records Release Authorization

Sharing Information for Purposes of Payment: I consent and authorize Scientific Therapy to release information contained in any financial or medical records, including but not limited to: diagnosis and treatment, information concerning communicable disease, drug or alcohol abuse, psychiatric diagnosis and treatment, medical history, lab results, progress notes and other related information to insurance companies and its agents, Medicaid or Medicare, or any other entity responsible for paying or processing payment, utilization management, or consulting and/or follow-up care.

Sharing Information for Purposes of Treatment: Scientific Therapy may share patient information with all members of their treatment team, both within this office and with other providers (personal and institutional) in order to supply quality health care and provide the educational/wellness programs specified in some insurance plans.

Sharing Information for Purposes of Operations: Patient health information may be referenced as necessary for ongoing operations of this office, (including but not limited to) the credentialing processes, peer review, accreditation, and compliance with state and federal laws.

Sharing of Information to Family or Representative of Minors: The following individuals are authorized to view, discuss, and/or obtain the patient's health care information and may seek medical care and make decisions in relation to advice rendered from Scientific Therapy and/or its employees. (Please provide full names and relationship to patient.) _____

Consent to Treatment

The undersigned consents to any examination or medical treatment, and/or services rendered to the patient by Scientific Therapy in their best judgment during the course of diagnosis and treatment. It is understood that the practice of medicine is not an exact science, and no guarantee can be given by anyone as to the results that will be attained from any diagnosis or treatment.

Financial Responsibility and Policies

In consideration of medical services rendered or to be rendered, I hereby irrevocably assign Scientific Therapy all rights, title, and interest in the benefits payable to said services rendered. Said irrevocable assignment and transfer shall be the recovery on said insurance policy, but shall not be construed to be an obligation of this practice to pursue any such rights of recovery. This assignment shall not take away the patient/guarantor's standing to make claim or sue for benefits individually should coverage be denied by insurance carrier(s). I hereby authorize the insurance company(ies) to pay Scientific Therapy all benefits due under said policy(ies) for services rendered. I understand that I (patient/guarantor) am responsible for any services not covered by my insurance company(ies).

Accounts that remain unpaid will be turned over to a collection agency and may result in patients dismissal from Scientific Therapy, additionally a \$50 fee will be added to the amount previously owed. If a check is returned for insufficient funds, a \$30 fee will be added to the amount previously owed. All co-pays, deductibles, and co-insurance will be due on the date of service.

The undersigned certifies that he or she has read, understands, and accepts this authorization form, and is legal parent, guardian, or representative of the patient.

Printed Name of Patient

Date

Patient Signature