PATIENT INTAKE
MEDICARE
ENGLISH

Dear Patient/ authorized representative,

Don’t just sign on these forms...

Actually READ through what you are signing

to prevent confusion later.

Welcome to Surge Mobile Physical Therapy! We strive to provide our patients with excellent service & quality care. Our commitment to your well-being and health care is something that we take very seriously.

The most important question: Do you want to be here? Are you ready and willing to put in the work on your part to reach your personal physical goals?

Remember that we are here to help YOU reach your physical goals, however, we cannot force anyone to come to therapy to get results....

This means that if you are NOT fully convinced that physical therapy can help you, more than likely it will not, and you should not waste your valuable time here. Research shows that having a positive and willing mindset is key to succeeding in your physical therapy journey!

If you are serious about your physical care and are ready to get started, continue.

MEDICARE
Patient Intake Form

<u>All</u> Patients or Patients' Legal Representative, please complete all Sections

(1) Patient: (Full Legal Name or as on Insurance Card)

Name: Last First Initial Sr. Jr. , etc.

Address: Street Apt# City State Zip Code

Phone: (_____) ______-________ Home (_____) ______-________ Mobile (_____) ______-________ Work (_____) ______-_________ Emergency

Email:____

(2) Patient

Assigned Sex:

Birthdate: _____/_____/______

S.S # XXX/XX/_______ Last 4 digits

Legal Photo ID # _____________________
(Driver's License, Passport, Other State/Federal Photo ID)

(3) Condition to be treated: ____

Did this condition result in surgery? No Yes If Yes, date of surgery ____/____/____

Is this condition due to a work Injury? No Yes If Yes, date of accident ____/____/____

Is this condition due to a non-work accident? No Yes If Yes, date of accident ____/____/____

Have you had Therapy this year? No Yes If Yes, What PT OT SLP Where?___________

Are you currently receiving Home Health? No Yes If Yes, from whom?________________________
(i.e. any healthcare worker, aide assisting or doing something to <u>or</u> for you?)

Do you live in a nursing home? No Yes If Yes, what is its name? _____________________

Are you covered:

a. Under Black Lung Disease? No Yes
b. End Stage Renal Disease? No Yes
c. Large Group Health Insurance/Associated COBRA? No Yes
d. Veterans Affairs? No Yes

(4) Patient's Doctor: Please list the doctor who referred you to therapy, or your Primary Care doctor.

Dr.'s Name: Last First Initial MD, DO, DDS, Other

Office Phone: (____) _____-_______

Address: Street City State Zip Code

(5) Payer Information Primary:

Primary Insurance Company: ☐ **Traditional Medicare** ☐ **Rail Road Medicare** ☐ **Medicare Advantage (Part C)**

Insured's Name:___________________________________ **ID #** ________________ **Group #** __________________

All Patients or Patients' Legal Representative Please Sign Section 8 on Page 2

Copyrights Protected by BCMS, LLC

MEDICARE
Patient Intake Form

(6) Payer Information Secondary/Supplemental Insurance Company: (If YES, please complete)

Ins. Co. Name: ______________________________ **Insured's Name:** _______________________ **Ins. Ph.#**_____________

Insured is: _____**Patient** _____**Spouse** _____**Parent**

Patient ID #: _______________**Group. #** ________________ **Policy/Plan #:** _______________________________________

Claims Mailing Address:____

Street City State Zip Code

Employer Name: ____ **Employer Phone # (   )** ______- ________

Address: ____ __________________________

Street City State Zip Code

(7) Payment Authorization: *(Initials required for all 3 statements)*

__________ **Assignment of Insurance Benefits**

Initials

I authorize that the payment of my insurance benefits be made directly to Surge Mobile Physical Therapy for any services that are reimbursable by Medicare or any other insurance company, if I have one.

__________ **Guarantee of Payment**

Initials

I understand that all payments designated as 'the patient's responsibility' such as co-insurances and deductibles are due and payable at the time of service or statement receipt. I guarantee I will pay the amount deemed "my responsibility" by the billing statement due date.

__________ **Certification of Information**

Initials

I certify that the information I have provided Surge Mobile Physical Therapy for payment under the Social Security Act (Medicare) including, but not limited to, related accidents, illnesses or other insurers is accurate and truthful.

(8) Signature/ Date: I agree to all of the above. I hereby authorize the professional staff at Surge Mobile Physical Therapy to examine and treat me with outpatient physical therapy services for the injury or condition that I have been referred here for/referred myself to.

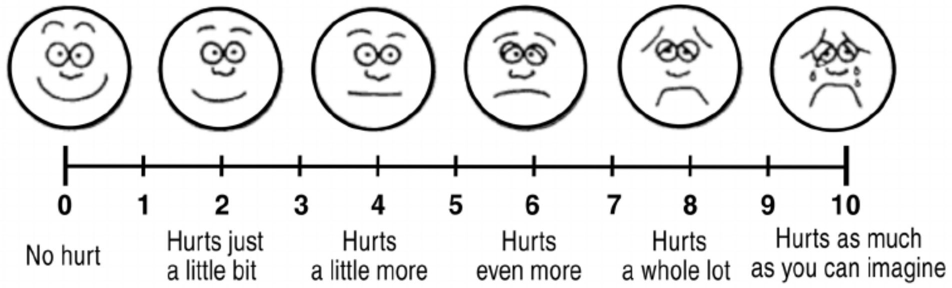
X____ __________________

Patient or Legal Representative's Signature **Today's Date**

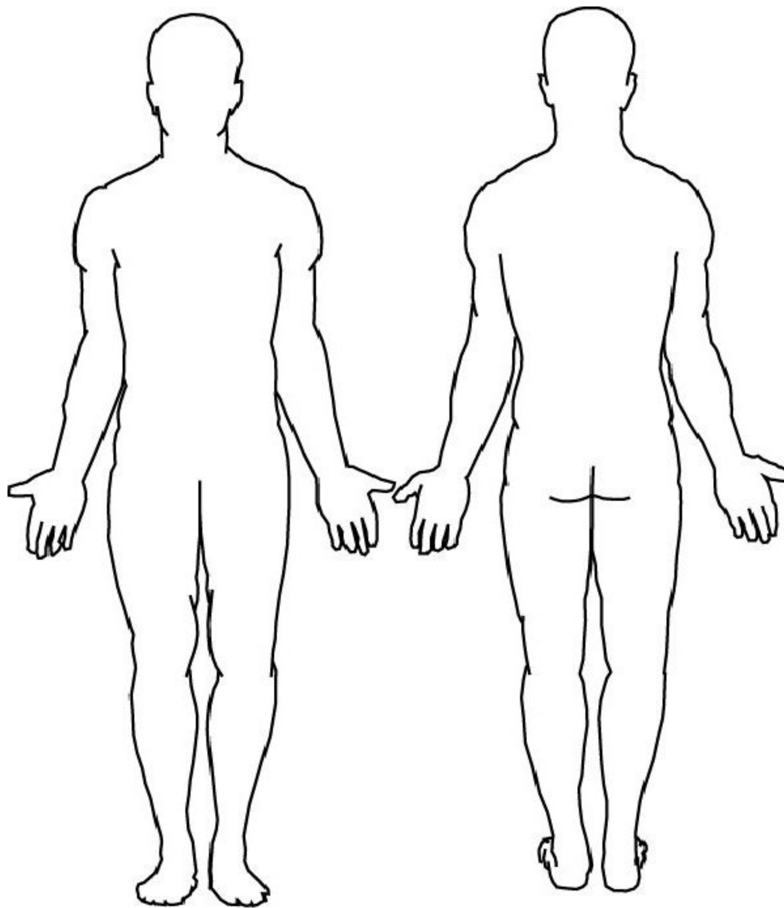
All Patients or Patients' Legal Representative Please Sign Section 8 on Page 2

Copyrights Protected by BCMS, LLC

Circle Your Pain Level:



Circle location to be treated below:



Initials are required by each Policy. By initialing, you understand and agree to adhere to all policies.

Medical Records Request Policy

________Initials. If you need any medical forms signed by our staff or need to get copies of your medical information, please allow up to 30 days of your request via email. If you request printed or email copies, there will be an associated fee for compiling and/or printing the documents: $25 for 1-20 pages, $0.50 per page thereafter.

Be Kind Policy

________Initials. Please be aware that if you are rude, aggressive, disrespectful, or inappropriate either verbally/physically to our staff/other patients, we reserve the right to refuse services and you will be asked to leave our establishment as this behavior will not be tolerated.

Commitment Policy

_______Initials. Your commitment to your physical therapy program is critical to your success. We will recommend a treatment plan of care and set goals for you. In order to reach those goals, you must do your part in attending every appointment AND doing your Homework Exercise Program as prescribed to see progress.It takes at least 8-10 weeks to see changes in musculoskeletal tissue!

Valid Card of File Policy

______Initials. We require every patient to keep a VALID debit/credit card on their account due to the $50 policy violations & in case insurance does not cover services, & to issue out refunds to go directly back to your card instead of waiting for a mailed check later on after your case is closed.

Appointment Policy

______Initials. We will text you appointment reminders. When you receive these, confirm your appointment by replying with the letter "C" ONLY. If you type anything else, we will NOT receive your response, and DO NOT KNOW YOU ARE COMING. We will schedule & provide you with your appointment times when you check out, ask for a print out if needed. If you misplace or forget your appointment times, please ask our front office staff, call, or text us to review these.

Arrive on Time Policy

_____Initials. Our goal is to begin your treatment sessions on schedule. Arrive at least 5 minutes prior to your appointment time, dressed comfortably, & be ready to begin.

Communication of changes

_____Initials. We may need to reschedule some of your appointments due to therapist availability, especially in emergency cases.

_____Initials. For your health safety, we require a letter of medical clearance after any patient hospitalizations to make sure you are safe to return to physical activity in therapy.

$50 NO SHOW / LATE CANCELLATION POLICY

We take your Physical Therapy VERY SERIOUSLY, because we care about your physical health. It takes time to see progress with therapy, and in order to get you better, we expect you to follow our recommended plan of care and to keep all your appointments. We also understand there may be a time when you need to cancel. We require 24-hour notice by phone call, voicemail, text, or email (missed calls do not count) if you need to cancel or reschedule. If you do not give 24 hour notice or do no show for your scheduled appointment, a $50.00 fee will be billed to your account, and it must be paid in order to continue your therapy sessions. If you're running late, call us immediately to check if we can accommodate for your late arrival. If you do not let us know you are going to be late and you show up >15 min late to your appointment, your session may need to be rescheduled, and we reserve the right to charge the fee for the lost session. When you cancel your appt on the SAME day of your appointment, to AVOID the $50 cancellation fee, you need to reschedule it during the same week. IF YOU DO NOT RESCHEDULE THIS MISSED APPOINTMENT DURING THE SAME WEEK, YOU HAVE MISSED YOUR APPOINTMENT & THEREFORE WIL BE CHARGED THE $50 CANCEL FEE. If you have more than 3 same-day cancellations OR no-shows, your case will be discharged,& we will notify your Referring Doctor.

Why do we charge the is fee? We do this to be respectful of everyone's time, you as the patient, us as the therapist, and to be fair to other patients that are making the time and effort to make it to every single appointment. When you do not show up to your scheduled appointment or cancel last minute, it wastes a slot that could have helped someone else get better. AGAIN, We take your physical health very seriously!

____

Patient/Guardian Printed Name **Date**

X____

Patient/Guardian Signature

To All Medicare Patients, we need your help and speedy communication to avoid billing you for 100% of your therapy services.

Many of you either have had or will have home health services paid for by Medicare. We should not provide Outpatient Physical Therapy or Occupational Therapy to patients who are having home health services of any kind, not just therapy services. The seven services listed below must be provided and paid for by your Home Health Agency if your physician has determined they are medically necessary. The services are:

- Skilled Nursing Services for the assessment and/or treatment of injuries or illnesses or giving medications/injections, monitoring and recording your vital signs (blood pressure, body temperature, pulse rate, and respiration rate), inspecting or inserting feeding tubes, catheters, wound care, etc.
- Occupational Therapy Services
- Physical Therapy Services
- Speech & Language Pathology Services
- Home Health Aide Services assist with basic personal care, bathing, linen changes, meal preparation, feeding, and incidental household services such as light cleaning, trash removal, etc.
- Medical Social Services
- Routine and nonroutine medical supplies

If you have had home health services within six months of being referred to us, we must know so we can verify your discharge from that service before starting PT. If you are referred for home health services while we are treating you, we must be informed before you start home health. If you do not advise us of your starting of a home health episode while receiving care from us, we will, as permitted by Medicare, hold you financially liable for the fees for the services rendered. It is YOUR RESPONSIBILITY to tell us if you have received in the past 4 months, or are currently receiving, or will be receiving any of the seven listed home health services. Your signature indicates that you have had the opportunity to ask questions and received answers to your satisfaction.

Patient's Printed Name: ______________________________

Patient/Representative Signature: X ____________________________ Date: __________

Dear patient,

As a Medicare provider, we have many mandates set forth by Medicare regarding covered/payable services. Medicare routinely uses the term “Medically Necessary” to describe when and why services are payable under their regulatory policies. We must comply with all of Medicare’s Coverage Policies in order to remain in good standing as a federal provider and to avoid billing for services that, under certain circumstances, are not statutorily covered or medically necessary.

We develop a Plan of Care for each patient based on testing & measures, observations, and clinical findings. Once we establish the Plan of Care, we discuss the Plan’s details with you, our patient, and proceed with it unless there is voiced opposition to it. The Plan is required to include:

- Functional and measurable goals (based on your past and current functional ability)
- Frequency (how often we schedule visits)
- Duration (how long we expect your episode of care to last)
- Certification by your attending physician (signed approval of the Plan)

It is the last bullet that is problematic for us. We send our Plans out for signature as soon as we put them into writing so that we can meet Medicare’s requirement of certification within 30 days. Medicare does provide a grace period for delayed certifications but**, in the end, the Plan must be signed, or it will be considered a Technical Denial i.e. non-covered service according to federal law. Under this statute the patient becomes financially liable for the services received. What we are asking is that, if your physician fails to certify your Plan of Care in a reasonable time, you will give his/her office a call and request that they immediately sign and send the Plan of Care to us to avoid any financial liability on your part.**

Please see the snippet below from the Medicare Benefit Policy Manual for your review and reference, if needed, for speaking to your physician.

> **Medicare Benefit Policy Manual - Certification and Recertification of Need for Treatment and Therapy Plans of Care 220.1.3 Section E.**
>
> *Denial for payment that is based on absence of certification is a technical denial, which means a statutory requirement has not been met. Certification is a statutory requirement in SSA 1835(a)(2) … if the service is provided by a supplier (in the office of the physician/NPP, or therapist) a technical denial due to absence of a certification results in beneficiary liability. For that reason, it is recommended that the patient be made aware of the need for certification and the consequences of its absence.*

As you know we appreciate the opportunity to treat you and will continue to do so in the interest of assisting you to achieve your highest level of pain-free function. If you have any questions, please feel free to contact me or any of our Front Office Staff.

Patient Name: ______________________________________ Date ______________________

Patient/Representative Signature: X ____________________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I recognize that outside of purposes for treatment, for payment, for certain healthcare operations or as permitted or required by law I must give my written authorization to Surge Mobile Physical Therapy to release any of my protected healthcare information.

My signature below indicates that I have been given this Notice of Privacy Practices for Surge Mobile Physical Therapy.

____
Patient's or Authorized Representative's Printed Name

X ____
Patient's or Authorized Representative's Signature

____
Date

Copyrights Protected By BCMS, Inc.
Written Authorization For Use Required

Patient Payer Insurance Verification Form

Patient Name:____

Date Verified:__________________ Verified By: ____________________

As a courtesy to you, we contacted your insurance company to check your available Outpatient Physical Therapy Benefits. Below is a summary of the information we were given. If you have any questions regarding your financial responsibilities, please ask. **We strongly recommend that you also contact your insurance carrier to confirm your benefits as we are sometimes given information that may be incorrect. Surge Mobile Physical Therapy is NOT responsible for any inaccurate information we receive and will bill you for any balances that your insurance company indicates as your responsibility/not covered.** The benefit coverage information that we receive from your insurance is always an estimate, NOT a guarantee of full coverage for services rendered. Any estimated amounts not covered by your insurance that are your responsibility are due at the time of your visit and must be paid in order to render services. After we send your claims to your insurance, all your visit claims are subject to final approval by your insurance plan after we render services; therefore, the amount due is subject to change after we see you. Inform the front office staff of ANY changes to you insurance coverage or if your insurance has terminated at the time of services. Any due balances remaining for your care will be billed to you via mail and email, and you may pay via mailed check, by calling the clinics- Olmito (956) 413-7799, Port Isabel (956) 443-3844, or online through our website at www.surgemobilephysicaltherapy.com. Any unpaid past due balances with more than 120 days of non-payment will be sent to collections.

Patient Diagnosis Info:

Areas to be treated per referral: ____

Payer Info:

Primary Insurance:____

Benefits Effective: ____________Plan Year:_______ Visits Allowed:_______Visit used:_______

Adjustor Name:______________________Phone:________________Fax:_________________

Network: IN | OUT | Out but Auth

Your policy requires: Referral from Physician | Pre-Authorization

According to your insurance, your Responsibility for payment is as follows:

Co-Pay:____________________________ Co-Insurance%:____________________

Deductible Met: YES | NO. Remaining Amount To Be Met:________________
1st Authorization #: ______________Time Restriction:____________ Visit Restriction:__________

Comments:____

Secondary Insurance:____

Benefits Effective: ____________Plan Year:_______ Visits Allowed:_______Visit used:_______

Adjustor Name:______________________Phone:________________Fax:_________________

Network: IN | OUT | Out but Auth

Your policy requires: Referral from Physician | Pre-Authorization

According to your insurance, your Responsibility for payment is as follows:

Co-Pay:____________________________ Co-Insurance%:____________________

Deductible Met: YES | NO Remaining Amount To Be Met:________________

1st Authorization #: ______________Time Restriction:___________ Visit Restriction:_________

Liability Claims/Facility LOP Obtained on:_____________________

Comments: _____________________________________

PAYMENT RESPONSIBILITY ACKNOWLEDGEMENT
FOR INSURED PATIENTS

Co-Pay or Co-Insurance Due Each Visit: _________________

Current Patient Balance**:** ____________________________

If this is only a portion if what your payment responsibility is per visit, you will be billed monthly for the remaining portion. All copayments and coinsurances and deductibles are expected at check in.

I understand & agree to my insurance benefit & payment information.

____________________________________ ______________________

Patient/Guardian Printed Name **Date**

X ___________________________________

Patient/Guardian Signature

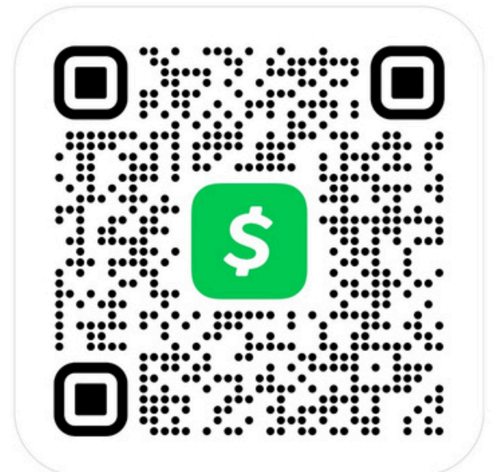
SURGE
MOBILE PHYSICAL THERAPY

Payment types accepted:

- DEBIT/ CREDIT CARD
- CHECKS:
  - RETURNED CHECK FEE: $5
- EXACT CASH
- CARE CREDIT
- CASH APP : $SurgePT

Tipo de Pago Aceptado:

- TARJETA DEBITO/CREDITO
- CHEQUES
  - CARGO POR CHEQUE DEVUELTO: $5
- EFFECTIVO EXACTO
- CARE CREDIT
- CASH APP : $SurgePT



SURGE
MOBILE PHYSICAL THERAPY

Questions about your bill?

Any questions about your bill you need to contact the billing department directly, as they handle any billing or refund issues. If you keep calling the clinic for any billing issues it will take longer as we still have to contact the billing department.

Phone number: 406-315-7395

¿Tiene preguntas sobre su factura?

Si tiene alguna pregunta sobre su factura, debe comunicarse directamente con el departamento de facturación, ya que ellos se encargan de cualquier problema de facturación o reembolso. Si continúa llamando a la clínica por cualquier problema de facturación, tardará más tiempo, ya que aún tenemos que comunicarnos con el departamento de facturación.

Número de teléfono: 406-315-7395

THE FOLLOWING FORMS ARE OPTIONAL ...

Dry Needling Consent for Physical Therapy Treatment

What is it? Dry Needling is a form of physical therapy in which fine needles are inserted into myofascial trigger points (i.e., painful knots in muscles), tendons, ligaments, or near nerves to help stimulate a healing response process in painful musculoskeletal conditions. Dry Needling is not acupuncture or Oriental Medicine; in other words, it does not have the purpose of changing the flow of energy ("Qi") along traditional Chinese meridians for the treatment of diseases. In fact, dry needling is a modern, science and evidence-based physical therapy intervention for the treatment of musculoskeletal pain and dysfunction.

We offer Dry Needling as a separate WELLNESS SERVICE. If interested in Dry Needling services, speak to your therapist. Our cost is $50 (CPT code 20560) for Dry Needling 1-2 Muscles/ using 1-2 Needles, and $100 (CPT code 20561) for Dry Needling 3 or more muscles/ using 3 or more needles.

Is it safe? After treatment some patients may experience temporary pain during and after the treatment, temporary soreness feeling (sometimes a few days), drowsiness, tiredness, or dizziness in about <3% of patients (if so, we advise you not to drive), minor bleeding or bruising (is considered normal), worsening of existing symptoms in about <3% of patients (which is not necessarily a bad sign), fainting (especially when needling the head and neck areas). Dry needling is very safe. However, serious side effects can occur in less than 1 per 10,000 treatments. The most common serious side effects is a pneumothorax/lung collapse (from air inside the chest wall). The symptoms of dry needling-induced pneumothorax commonly do not occur until after the treatment session, sometimes taking several hours to develop. The signs and symptoms of a pneumothorax may include shortness of breath on exertion, increased breathing rate, chest pain, dry cough, bluish discoloration of the skin, or excessive sweating. If such symptoms occur, you should immediately contact your physical therapist or medical physician. Nerves or blood vessels may be damaged from dry needling which can result in pain, numbness/tingling; however, this is a very rare event and is usually temporary. Damage to internal organs has been reported in the medical literature following needling; however, these are extremely rare events (1 in 200,000). Only single-use, disposable needles are used in this clinic. **Let your therapist know if you have:** Seizures, pacemaker/implants, taking anticoagulants, antibiotics for an infection, damaged heart valve, metal prosthesis, risk of infection, pregnant, metal allergies, diabetic impaired wound healing, hepatitis B, HIV, or other infectious disease.

I have read & understand the information above & will speak to my therapist if I am interested.

____

Patient/Guardian Printed Name **Date**

X____

Patient/Guardian Signature

PELVIC FLOOR EVAL & TREATMENT CONSENT FORM

* I acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor dysfunction, Pelvic floor dysfunctions include, but are not limited to, urinary or fecal incontinence; difficulty with bowel, bladder, or sexual functions; painful scars after childbirth or surgery; persistent sacroiliac or low back pain; or pelvic pain conditions.

* I understand that to evaluate my condition it may be necessary, initially and periodically, to have my therapist perform an internal pelvic floor muscle examination. This examination is performed by observing and/or palpating the perineal region including the vagina and/or rectum, This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, scar mobility, and function of the pelvic floor region. Such evaluation may include vaginal or rectal sensors for muscle biofeedback.

* Treatment may include, but not be limited to, the following: observation, palpation, use of vaginal weights, vaginal or rectal sensors for biofeedback and/or electrical stimulation, ultrasound, heat, cold, stretching and strengthening exercises, soft tissue and/or joint mobilization, and educational instruction.

* I understand that in order for therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from attending therapy. I agree to cooperate with and carry out the home program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

By Signing for this section, I agree and understand all the above and below:

The purpose, risks, and benefits of this evaluation have been explained to me. I understand that I can terminate the procedure at any time. I understand that I am responsible for immediately telling the examiner if I am having any discomfort or unusual symptoms during the evaluation. I have the option of having a second person present in the room during the procedure If I choose to. I understand that I am responsible for communicating this with my examiner, and that I am responsible for bringing this second person to my appointment(s), as the clinic does not provide one at this time.

By signing Below, I have read, understand, and agree with the Pelvic Floor Consent Form.

____ ______________

Patient/Parent/Guardian Printed Name Date

X____

Patient/Parent/Guardian Signature

Photography/Testimonial Authorization Consent Form

(OPTIONAL)

Surge Mobile Physical Therapy uses photography/video/audio recordings for the purpose of:

* Analyzing your movements/posture during evaluations and throughout your episodes of care to track your progress.

* Analyzing your movements/posture during evaluations and throughout your episodes of care to track your progress.

* Posting successful testimonials or educational content on our website or other social media platforms.

* As a result, your or child's images/videos/voice/written testimonials may appear on our website or other social media platforms if you allow it.

Purpose of Authorization: By signing this authorization form, I am providing Surge Mobile Physical Therapy, hereafter identified as the Company, to distribute and share my/my child's client testimonial that is provided. Sharing my/my child's client testimonial may include posting the information on the company website, posting the testimonial information on the Company's social media pages, and including my/my child's testimonial on printed advertisements and promotions. I agree that I am voluntarily sharing my/my child's testimonial about services from the Company, and I am receiving no financial remuneration from the Company for providing such testimonial and allowing them to use my/my child's protected health information for marketing purposes.

Right to Revoke: I understand that I have the right to revoke this authorization at any time by providing a written request to the Company. I understand that if I choose to revoke this authorization, it will become effective on the day of the revocation of the authorization. Any prior uses and disclosures of my testimonial with my protected health information will not be subject to the revocation of the authorization. I understand that the Company will make it best effort to remove my testimonial and protected health information from the Company's website and other social media pages.

By signing below, I agree and acknowledge that I have read and understood all of the elements of this authorization for use of my/my child's client testimonial. This authorization is continuous, meaning Surge Mobile PT will not remove my/my child's testimonial from the website or other social media pages unless I specifically request a revocation of this authorization through a written request to the company. I release Surge Mobile Physical Therapy, from any and all liability that may arise in connection with such use. I certify that I am 18 years or older OR that my parent/guardian has signed below.

____ ______________

Patient/Parent/Guardian Printed Name **Date**

X____

Patient/Parent/Guardian Signature

AUTHORIZATION FOR RELEASE OF INFORMATION

Authorization is not required for the Use or Disclosure of Information Related to Treatment, Payment, Healthcare Operations or if Required by Law or Rules

You May Refuse to Sign this Authorization

(1) **Patient's Printed Name**:

____
Last First Initial or Other

Date of Birth: ____/_____/___ Insurance # exactly as on card (including letters)__________________

(2) Surge Mobile Physical Therapy will only disclose the protected health information you want disclosed.

Check only one box to tell Surge Mobile Physical Therapy the specific information you want disclosed/released:

- ☐ Do NOT release any information other than for treatment or payment (skip sections 3-5.continue to section 6)
- ☐ Limited information (complete ALL Sections)
- ☐ ALL records regarding my care at Surge Mobile Physical Therapy to any requesting party (skip 3 and 4)

(3) Complete only if you selected "limited information". Please initial all that apply:

_____ Evaluation/Examination ______ Attendance _____ Correspondence re: your Physical Therapy Services
_____ Past Medical History ______ Treatments _____Other ______________________

(4) Complete only if you selected "limited information". I only authorize the release of information to the individuals/entities identified below by name:

Spouse: ______________________ Attorney: ______________________
Parent: ______________________ Employer: ______________________
Friend: ______________________ School: ______________________
Other: ______________________ Other: ______________________

(5) Check only one box indicating how long Surge Mobile Physical Therapy can use this authorization:

- ☐ Disclose my information indefinitely (as long as Surge Mobile Physical Therapy has custody of my files)
- ☐ Disclose my PHI for the following period beginning ___/___/_______ and ending ___/___/________

(6) Please initial all items below indicating that you have read and understand the rights or information below:

_______ I understand that this authorization does not expire unless I have indicated an expiration date above
_______ I understand that I can refuse to give authorization without fear of retaliation or treatment limitations
_______ I understand that if I give authorization I may revoke it at any time by notifying this Surge Mobile Physical Therapy in writing
_______ I understand that the information used/disclosed as a result of my authorization may be subject to re-disclosure by the recipient and may not be protected by Federal privacy regulations once in the recipient's possession
_______ I understand that if Surge Mobile Physical Therapy requests my authorization it is required to tell me the purpose and to whom my PHI (protected health information) is being released to
_______ I understand that I will receive a copy of this authorization after I sign it and before I sign, if I request it
_______ Surge Mobile Physical therapy will not be compensated for using or disclosing my PHI unless related to treatment or payment procedures unless specific permission is obtained by the patient after full disclose of purpose & intent

X______________________________ **or** ______________________________

Signature of Patient Date **Signature of Parent or Authorized Representative Date (Indicate the Relationship)**