AUTHORIZATION & INFORMED CONSENT

BODYWORKS

☐ **AUTHORIZATION TO RECEIVE A COMPLIMENTARY CONSULTATION**

I, the undersigned, agree to a Complimentary Consultation at BODYWORKS. I understand that this Consultation is not a substitute for an Evaluation and is provided to me as a professional courtesy. By initialing below, I acknowledge this fact and give the therapist permission to perform a physical screening examination and, if needed, advise me on a plan of treatment. Neither I, nor my insurance company, will be billed for this service.

Initials: _____ Date: _____

☐ **AUTHORIZATION TO RECEIVE AN EVALUATION**

I, the undersigned, agree to an Evaluation at BODYWORKS. I understand that the Evaluation will determine my diagnosis, prognosis, and outcome of treatment. By returning for subsequent appointments, I demonstrate my authorization to receive and participate in a treatment program in accordance with the facility operating policies, which are available for review at my request.

Initials: _____ Date: _____

☐ **ACKNOWLEDGMENT OF HIPAA (HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT) REGULATIONS**

I, the undersigned, am aware of the HIPAA provisions that protect the privacy of my medical information and records. I acknowledge that I am aware a written summary of these provisions is available for my review and that, in general, any information about my health care, or payment for that care is considered confidential and protected by BODYWORKS' practice which is consistent with the HIPAA Act of 1996 with regard to Protected Health Information (PHI).

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BODYWORKS' Notice of Privacy Practices provides a more complete description of permitted uses and disclosures. BODYWORKS will accommodate any reasonable request for restricted communications. All communication will be routed as verified by me during the consultation/evaluation/orientation and insurance verification process as unless otherwise indicated by me on a separate *Request for Restricted Communications Form*.

Initials: _____ Date: _____

☐ **AUTHORIZATION TO RELEASE MEDICAL INFO TO HEALTH CARE PROVIDERS INVOLVED IN YOUR TREATMENT**

I, the undersigned, hereby authorize BODYWORKS to release/receive pertinent records – on paper, in electronic form, or verbally – and information regarding my condition, such as: history, physical condition, authorizations, insurance billing and treatment rendered, to/from other health care professionals or organizations involved in my care or payment of care. I understand that purpose of electronic communications in the form of email or other information technology is to allow more rapid action and decision-making to assist in my care.

Initials: _____ Date: _____

☐ **AUTHORIZATION TO ASSIGNMENT OF BENEFITS AND ACCEPTANCE OF FINANCIAL RESPONSIBILITY**

I, the undersigned, have medical insurance coverage and assign directly to BODYWORKS/PRAXIS CORPORATION medical benefits, if any, payable to me for services rendered. I understand that I am responsible for all charges whether paid for by my insurance or not. I authorize the release of only pertinent medical information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment. In addition, I understand that PRAXIS Corporation reserves the Right to Recover attorney fees and costs associated with the collection of my account in the event that my account is placed with a collection agency to recover the balance due.

Initials: _____ Date: _____

Patient/Claimant Signature: _____ Date: _____

Legally Authorized Representative: _____ Date: _____

Signature of Witness: _____ Date: _____

Note: The above authorizations will be in effect unless revoked by written notification from the patient.