

# MSI PHYSICAL THERAPY

## CONSENT FOR TREATMENT

I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while a patient at MSI Physical Therapy. I consent to the use of my otherwise protected health information for my treatment to enhance MSI practice operations, and to secure insurance reimbursement. I authorize MSI Physical Therapy to obtain any necessary medical records from other practitioners for the sole purpose of ongoing treatment. I understand that I will be treated in an open air environment and limited personal health information may be unavoidably disclosed.

## ASSIGNMENT OF BENEFITS

I instruct and direct \_\_\_\_\_ to pay by check made payable to

MSI Physical Therapy  
40 Main Street  
Chatham, NJ 07928

Benefits allowable according to my insurance plan for services rendered. I consent to the release of protected health information for the purpose of obtaining reimbursement. I authorize a representative of MSI Physical Therapy to initiate a complaint to the insurance commissioner for any reason on my behalf.

I understand that if my account is not paid directly, I am responsible for the full amount and any costs associated with the collection of this debt, including attorney fees, collection agency commission, and other legal fees.

A photocopy of this assignment shall be considered as valid as the original.

## ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. You have the right to review our Notice and ask questions about our privacy practices. The terms of our notice may change. Upon request, a copy of our revised notice will be made available to you.

By signing this form you acknowledge that you have received our Notice of Privacy Practices.

\_\_\_\_\_  
PRINT NAME OF PATIENT

\_\_\_\_\_  
SIGNATURE OF PATIENT/GUARDIAN

\_\_\_\_\_  
Date