

South Bay Sports and Preventive Medicine Associates, Inc.

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2039 Forest Avenue #204-A
San Jose, CA 95128
(408) 293-7767 Fax (408)271-9169

AUTHORIZATION FOR OUTPATIENT TREATMENT

I have been informed of the treatment considered necessary and that the treatment and procedures will be performed by appropriately licensed physical therapists, occupational therapist, chiropractors, athletic trainers, physical therapy assistants, and exercise physiologists employed by South Bay Sports and Preventive Medicine Associates, Inc. (SBSPMA). Authorization is hereby granted for such treatment and procedures as prescribed by my physician, or directed under California "direct Access".

I certify that the information provided to SBSPMA by me is correct, and I accept full responsibility for all charges*. I hereby assign and authorize payment directly to the above named clinic of all applicable insurance benefits. If my current policy prohibits direct payment to SBSPMA I hereby instruct and direct SBSPMA to bill me directly for the insurance payment, including all costs incurred in collecting the balance if the account becomes delinquent, such as court costs, attorney's fees, and/or collection agency commissions or charges.

*Patients with valid workers' compensation claims are not responsible for treatment charges.

MEDICAL RECORDS AUTHORIZATION

SBSPMA is hereby authorized to release information pertinent to my treatment to any doctor, insurer, compensation carrier, attorney or other agency legally involved with my case (proof of relationship will be confirmed).

MEDICARE PATIENTS

I certify that the information provided to SBSPMA by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information above me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claims. I request that payment of authorized benefits be made on my behalf.

I authorize SBSPMA to initiate a complaint to the Insurance Commissioner for any reason on my behalf. A photocopy of this assignment shall be considered as effective and valid as an original.

Patient Signature

Witness

Date

As parent or legal guardian, I have read, understand, and agree with all items stated above and hereby authorize SBSPMA to administer physical medicine treatment as prescribed to _____

Patient Name

Parent/Guardian Name

Parent/Guardian Signature

Date