Client Name:_________________________________ Backway's Physical Therapy

You have the right to revoke the following authorizations, unless we have already taken action relying on the authorization. Requests to revoke any authorizations must be made in writing. ____________ (please initial)

Client Signatures are Necessary For:

ASSIGNMENT OF BENEFITS

I hereby assign payment directly to Backway's Physical Therapy or Ruth S. Backway, P. T., of the medical benefits, if any, otherwise payable to me, for health care services. I understand that I am financially responsible to Backway's Physical Therapy or Ruth S. Backway, P. T. for charges not covered by this assignment. This assignment will be in effect until my account is paid in full.

Signature of Insured ____________________________________ date: ___________________

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize Backway's Physical Therapy, Ruth S. Backway, P. T., or her duly appointed representative, to release any information acquired in the course of my examination or treatment to my Insurance Company. This authorization will be in effect if my account is audited or until paid in full.

Signature of Client ____________________________________ date: _________________

Signature of Insured/Guardian(if applicable) ____

CONSENT FOR MUTUAL EXCHANGE OF INFORMATION

I authorize the mutual exchange of information regarding myself, or my dependent, between Backway's Physical Therapy and/or Ruth S. Backway, P. T., or her duly appointed representative, and the following person(s) or professionals:

____

____

other professionals involved in my healthcare, or that of my dependent, at any time.

Signature of Client ____________________________________ date: _________________

Signature of Insured/Guardian(if applicable) ____

CONSENT FOR TREATMENT

I grant permission to licensed personnel at Backway's Physical Therapy, to provide treatment to me, or my dependent, using any and all of the techniques they know, including Structural Integration bodywork, dialogue and movement training; TMJ techniques; soft tissue, visceral and joint mobilizations, craniosacral techniques, and any other techniques they believe will benefit me, until I am discharged from their care.

Signature of Client ____________________________________ date: _________________

Signature of Insured/Guardian(if applicable) ____

CONSENT FOR USE OF INFORMATION FOR PRESENTATIONS/PUBLICATIONS ***(Optional)***

I grant permission, now and in future, to Backway's Physical Therapy, or their duly appointed representative, to use my records, or those of my dependent, for other consultations and for professional education and publications, **providing reasonable precautions are taken to guard against the disclosure of the client's identity**. Backway's Physical Therapy will not condition treatment on my signing this authorization, and I have the right to inspect any information to be used for these purposes.

Signature of Client ____________________________________ date: ________________

Signature of Insured/Guardian(if applicable) ____