**Health Insurance Billing Consent Form/Consent To Treat and Share Medical Info**

Health Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Benefits Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Member ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Patient Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Sponsor’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sponsor DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sponsor’s Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sponsor’s Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s policy group #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Member ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*I consent to necessary examination procedures and/or treatment for my child by Annette Thomas, MSPT.*

***INITIAL:\_\_\_\_\_\_\_\_\_***

*I authorize the release of any medical or other information necessary to process claims. I also request payment of benefits to Power Up Physical Therapy & Fitness, L.L.C. for services provided and claimed.*

***INITIAL:\_\_\_\_\_\_\_\_\_***

*I have been given a copy of Power Up Physical Therapy & Fitness, L.L.C. Notice of Privacy Practices, will review it and keep it on file. I authorize Annette Thomas, MSPT to communicate any relevant evaluation and/or treatment results with my child’s physician.*

**Parent Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_**