Cardenas and Associates Physical Therapy
Medicare Program Patient Consent and Payment Authorization

I request rehabilitation services from Cardenas and Associates Physical Therapy and consent to the treatment ordered by my physician who directs and monitors my care. Cardenas and Associates Physical Therapy is not liable for any act or omission when following the instructions of my physician.

I consent to the release of information and a copy of my clinical records to Cardenas and Associates Physical Therapy by any health care provider.

I do not receive Medicare benefits from a managed care organization and I am eligible to receive Medicare Part B benefits from a provider of my choice. I certify that the information given by me in applying for payment under the Medicare program (Title XVIII of the Social Security Act) is correct. I authorize release of all records required to act on this request and that payment of authorized benefits be made on my behalf.

____ I do not have Medicare Supplemental Insurance.

____ I have Medicare Supplemental Insurance with:

Name of Insurance Company: ____

____ I have health benefits provided to me by the Medi-Cal Program.

I hereby assign payment of any Medicare supplemental insurance benefits to Cardenas and Associates Physical Therapy. In the event the insurance benefits are paid directly to me, I agree to make immediate payment or endorse and send the check to Cardenas and Associates Physical Therapy. If I do not have secondary insurance, I agree to pay the deductible and/or coinsurance when billed unless other arrangements are made in advance.

The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient or is duly authorized by the patient to execute the above and accept its terms.

____
Patient Name (please print)

____ ___________________________________
Signature Date

If patient did not sign this form, what is the relationship of the signer to the patient?

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Reason for not signing:____