1/2018

Midlands Therapy Services, Inc.
Insurance Release Form
Patient Information & Therapy Authorization

Name:_____Date of Birth_____Age_____Start of Care Date:_____
Address:_____Referring Physician:_____
_____Physician's phone #_____
Phone: (home)_____(work)_____(cell)_____(other)_____
Caregivers Name (and relationship)_____

Primary Insurance Coverage Information
Payor:_____Plan_____Policy#_____Group#_____

Claims address:_____Phone:_____

Policy Holder Information:

Full Name:_____**Relationship to patient:**_____**DOB:**_____

Employer:_____Gender:_____

Address and Phone # (if different than Patient)_____

Secondary Insurance Coverage Information
Payor:_____Plan_____Policy#_____Group#_____

Claims address:_____Phone:_____

Policy Holder Information:

Full Name:_____**Relationship to patient:**_____**DOB:**_____

Employer:_____Gender:_____

Address and Phone # (if different than Patient)_____

CONSENT TO TREATMENT

I understand that I have been referred for therapy services and care with Midlands Therapy Services. I understand that I the right to ask and have any questions answered prior to receiving any treatment, including any risks or alternatives to the treatment plan that has been prescribed by my physician and/or recommended by my therapist. By signing this agreement, I consent to have Midlands Therapy Services provide treatment and care as prescribed by my physician and/or recommended by my therapist.

I authorize Midlands Therapy Services to use and / or disclose my protected health Information to physicians, payers of health care services and other health care providers to help provide appropriate treatment for my child.

I hereby authorize Midlands Therapy Services to furnish my insurance company(s) any information that may be required in order to determine benefits and process claims. I authorize payment of medical benefits to Midlands Therapy Services for services rendered to me. I certify by my signature that I have read the above and agree to these policies.

Patient Name:_____

Caregiver's EMAIL Address:_____

Patient / Authorized Representative signature:_____**Date**_____

Therapist Signature:_____**Date:**_____