HILTON HEAD PHYSICAL THERAPY, LLC.

Release of Information

I authorize the release of information to Hilton Head Physical Therapy, LLC. (HHPT, LLC) of any medical information necessary for treatment and/or to process claims for services rendered by HHPT, LLC.

This authorization authorizes HHPT, LLC to disclose any information furnished HHPT, LLC or obtained by HHPT, LLC in connection with my treatment (including information concerning a related Medicare), to any physician, government agency (including the Social Security Administration or any of its intermediaries or carriers), insurance company or health care facility requesting such information.

Patient and authorized Patient Representative agree to execute any documents and perform any acts that HHPT, LLC may reasonably request with regards to therapy services.

The undersigned warrants and represents that attached hereto are originals or certified copies of any applicable powers of attorney, health care surrogate forms or court orders appointing as the legal guardian of the Patient.

Patient name (print):______________________________ DATE:_______________

Signature of Patient or authorized Patient Representative (*if applicable)*:_______________

Name: _______________ Relationship to Patient_______________

Reimbursement Coverage

Patient or authorized Patient Representative hereby assigns to HHPT, LLC all private medical insurance benefits (primary and secondary, including med.gap providers) or other benefits to which Patient may be entitled for any therapy series rendered by HHPT, LLC.

Patient or authorize Patient Representative authorizes and directs HHPT, LLC to apply and file for all such benefits on behalf of Patient.

Patient or authorized Patient Representative agrees that he/she shall be jointly and severally financially responsible for any portion of HHPT, LLC invoice that is not paid, including but not limited to (i)any applicable deductibles or co-insurance, (ii) any non-insured or non-covered services authorized, or (iii) any charges in excess of payment limitations imposed by third party payers, except in the event of Medicare denial or Medicaid eligible recipients.

Patient of authorized Patient Representative authorizes HHPT, LLC to represent Patient during the appeals process in the event of a denial of Medicare benefits.

TERMS

This patient consent and authorization given to HHPT, LLC as set forth above will remain in full force and effect until terminated in writing by patient or authorized patient representative.

Signature of Patient: ______________________________ Date_______________

Signature of Patient Representative:

Name ______________________________ Relationship to patient: _______________

Witness ______________________________ Date_______________