



MI Therapy Clinic

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PAGE 1 OF 1

PATIENT CONSENT FORM

Patient Name

Date

Consent for treatment, insurance assignment, and privacy acknowledgement

I hereby authorize MI Therapy Clinic and any of its contractors (collectively the Provider) to render physical, occupational, or speech therapy services that the Provider and the patient's physician determine to be necessary.

I assign and transfer to the Provider the right to all payments, including Medicare, Medicaid, and/or private insurance benefits, for therapy services rendered. I authorize the Provider to apply and file for all such benefits on my behalf.

I authorize the Provider to disclose or discuss information related to my therapy services with my physician, insurance company, family members, and government agencies upon request. I understand it is my responsibility to know my insurance coverage and that I am responsible for any portion of payment not paid by insurance, except payments denied by Medicare or another carrier for non-medical reasons.

I certify that all information provided to the Provider is true and accurate. I understand that under HIPAA (Health Insurance Portability and Accountability Act of 1996) I have certain privacy rights regarding my protected health information.

This information may be used to conduct, plan, and direct my treatment and follow-up care; obtain payment from third-party payers; and conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand the Notice of Privacy Practices. I understand this organization may update its Notice from time to time, and I may request the most current version in writing. I may also request in writing that the Provider restrict how my private information is used or disclosed for treatment, payment, or healthcare operations.

Patient Authorization

By signing below, I acknowledge and consent to the terms above.

Patient Signature (or Legal Representative)

Date

Printed Name (if signed by representative)

Relationship

Therapist Use Only

Therapist Signature

Date