



Kevin Wicks
Physical Therapist

Thomas Gilberti, Jr.
Licensed Athletic Trainer

Donald Herc
Physical Therapist

Walter "Reiko" Reyes
Physical Therapy Assistant

Timothy Loy
Physical Therapist

Tony Teresi
Physical Therapy Assistant

Leslie Williams
Physical Therapy Assistant

PATIENT NAME: (Please Print) _____

Thank you for placing your confidence in us by choosing us to provide for your rehabilitative needs. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

AUTHORIZATION FOR TREATMENT:

I hereby authorize Gulfcoast Physical Therapy & Performance Center, Inc., through its appropriate personnel, to perform on me (or the above named patient) appropriate assessment and treatment procedures relating to my diagnosis.

RELEASE OF INFORMATION:

I hereby authorize Gulfcoast Physical Therapy & Performance Center, Inc. to release to my physician, insurance company, attorney and/or other appropriate parties, any information acquired in the course of my (or the above named patient's) treatment

ASSIGNMENT OF INSURANCE BENEFITS/DIRECT PAYMENT:

I authorize my insurer to pay any benefits directly to Gulfcoast Physical Therapy & Performance Center, Inc. I agree to pay Gulfcoast Physical Therapy & Performance Center, Inc. the full and entire amount of all bills incurred by myself or the above named patient to include any amount due after payment has been made by my insurance carrier.

MEDICARE DEDUCTIBLES & CO-PAYMENTS:

Medicare reviews our charges and expenses on an ongoing basis in order to ensure that they are fair and competitive. We will file your Medicare claim and also (if you wish) your supplement insurance claim. **YOU ARE RESPONSIBLE FOR CO-PAYMENTS & PAYMENT OF YOUR YEARLY DEDUCTIBLE IF IT HAS NOT BEEN MET OR COVERED BY YOUR SUPPLEMENTAL INSURANCE PLAN.**

APPOINTMENTS:

Our time is reserved just for you. If you are unable to keep your appointment please notify us 24/hrs. in advance. Thank you.

By signing below, I acknowledge that I received the Notice of Privacy Practices and have had an opportunity to read it.

PATIENT SIGNATURE (or responsible person): _____ **DATE:** _____

PARENT OR LEGAL GUARDIAN (if applicable) _____ **DATE:** _____

OUR STAFF LOOKS FORWARD TO WORKING WITH YOU. OUR GOAL IS TO MAKE YOUR REHABILITATION BOTH PLEASANT AND SUCCESSFUL!