Ability Physical Therapy PLLC
PH: (406) 502-1210
Fax: (406) 205-4423
AbilityPT@icloud.com

1225 Birch Street Suite B
P.O. Box 4181
Helena, MT 59604
Web: Abilitypt.org

Assignment of Benefits:

I authorize payment directly to Ability Physical Therapy PLLC (or Angela Zendron) for services provided and billed. I authorize the release of any information requested by my insurance company. This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original.

______________________________ ______________________________
Child's name Guardian's name

______________________________ ______________________________
Guardian's Signature Date

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Notice of Privacy Practices:

I hereby acknowledge that I was offered a copy of the Notice of Privacy Practices (HIPAA Acknowledgement) for Ability Physical Therapy, PLLC. Additionally, I hereby consent to the use and disclosure of my child's personal health information for the purposes of treatment, payment, and health care operations.

______________________________	______________________________
Child's name	Guardian's name
______________________________	______________________________
Guardian's Signature	Date

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Authorization for release of Protected Health Information (PHI)

This form is used to release your PHI as required by state and federal laws. Your authorization allows the release of your PHI to a person or organization that you choose. Your authorization is voluntary and maybe revoked at any time by submitting a request in writing except to the extent that the action has already been taken to comply with it.

Patient Name: ____________________________________ DOB: _____/_____/__________

I, ______________________________, hereby authorize Ability Physical Therapy, PLLC to disclose and exchange specific and protected health information for treatment and planning purposes, from the records (written and/or electronic) of the above named child to/from the individuals, agencies, institutions, or organizations listed below.
I authorize Ability Physical Therapy, PLLC to contact the individuals, agencies, institutions, and/or organizations listed below for the purpose of reciprocal sharing of information regarding diagnosis, plan of care, treatment, treatment outcomes, or any other matter pertinent to the patient's physical therapy program.

Information to be shared with:
____
____
____
________.

By signing below, I consent to this release of pertinent and protected health information.

____ _______ ______________________________
Guardian's Signature Date